Samaritan Choice Plans

SUMMARY OF MATERIAL MODIFICATIONS & NOTICE OF REQUIRED DISCLOSURES

This document provides changes made to your Medical, Pharmacy and Vision benefits effective January 1, 2015. If you do not have a 2015 Samaritan Choice Medical, Pharmacy and Vision benefits Member Handbook, please call our Customer Service Department at 541-768-4550; Toll-free at 1-800-832-4580; TTY 1-800-735-2900. You can also visit our member portal for an electronic copy at MyHealthPlan.samhealth.org.

KEEP THIS NOTICE WITH YOUR 2015 SAMARITAN CHOICE PLANS' MEDICAL & PHARMACY AND VISION PLAN DOCUMENTS. THIS IS A LEGAL PART OF YOUR MEMBER HANDBOOK.

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

🡻 🡻 🡻 This section replaces language in the HOW AND WHEN TO ENROLL? and WHAT HAPPENS IF ELIGIBILITY CHANGES? sections on pages 15-17 in your Samaritan Choice Plans' 2015 Medical & Pharmacy Benefits member handbook and on pages 6-8 in your Samaritan Choice Plans' 2015 Vision Benefits member handbook. 🡻 🡻 🡻

How and when to enroll?

When you first become eligible: Most SHS employees become eligible the first day of the month after they become non-temporary employees. In the Senior Care Divisions of SHS, including but not limited to, Wiley Creek Community, employees who are regularly scheduled to work at least 20 hours per week are eligible for coverage under the Plan following completion of 6 months of employment. Coverage begins the first day of the month following 6 months of regular employment.

During this waiting period, you should file with the Human Resources office an enrollment form for yourself and any eligible dependents you wish to have enrolled in the Plan. The Human Resources office must receive this application 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 his or her 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. Your qualified domestic partner may enroll by submitting an enrollment application and completed Domestic Partnership Affidavit at the time of your initial enrollment or within 30 days of the partnership first becoming eligible according to the criteria stated in the Eligibility section. All other domestic partner applications will be subject to late enrollment provisions.

Please note: If you intend to have your newborn covered under the plan, it is imperative that you enroll your child as soon as possible, but no later than 60 days following birth or adoption. Please contact your designated Human Resources Department for assistance. The Plan covers your newborn child for the first 30 days after the child's birth if the child is enrolled in coverage within 60 days. An adopted child will be covered for the first 30 days from the time of placement with you for adoption if the child is enrolled in coverage within 60 days. "Placement" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. If the child's placement for adoption does not become final, coverage for the child will end on the date the child is removed from placement.

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

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 (which is the month of December) to enroll. If you then enroll, coverage will become effective as of the following January 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 (including benefits consisting of medical care under any hospital or medical services policy or HMO). However, you must state in writing that you do not want to enroll yourself (or a dependent) in the Plan due to other coverage. 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.
- You are newly eligible under Oregon's Family Health Insurance Assistance Program, FHIAP, and a request for enrollment is made within 30 days after issuance of FHIAP eligibility

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 dependents' other coverage). However you must request enrollment within 30 days after you or your dependents' 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.

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009, supplements the HIPAA special enrollment notice by allowing eligible employees and dependents to enroll under the plan under the following circumstances:

- The employee's, spouse's, domestic partner's, or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, or
- The employee, spouse, domestic partner, or dependent becomes eligible for a premium assistance subsidy or Medicaid coverage under Medicaid or Children's Health Insurance Program (CHIP).

Employees and dependents must request special enrollment under this provision within 60 days of the loss of Medicaid or CHIP coverage or within 60 days after the employee or dependent is determined to be eligible for a Medicaid or CHIP subsidy.

To request special enrollment or to obtain more information, contact your designated Human Resources department 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 (unless your employment was terminated for reasons of gross misconduct). Refer to the Continuation coverage section for details.

Transfer to non-benefited position: If you cease to be a regular, fulltime employee (i.e., you cease to be assigned to a .50 FTE or greater position), then the coverage for you and your dependents will ordinarily end on the last day of the month in which your transfer of position occurs. However, you and your covered dependents may then be able to continue coverage on a self-pay basis. 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. 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 domestic partnership affidavit 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. 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. (Please also refer to the Disclosures section for information on Michelle's Law P.L. 110-381; page 54 for additional information) Your qualified dependent children may continue their coverage on a self-pay basis. Refer to the Continuation coverage section for details.

Your enrollment responsibilities

As a Samaritan Choice member, you are responsible for doing the following actions within the specified timeframe as described below.

- Within 30 days of eligibility, you should file with the Human Resources office an enrollment form 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 his or her children once they become eligible for coverage on the date of the marriage.
- Your qualified domestic partner may enroll within 30 days of the partnership first becoming eligible according to the criteria stated in the Eligibility section by submitting an enrollment application and completed Domestic Partnership Affidavit.
- 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".

🡻 🡻 🡻 This section replaces language in the PLAN BENEFITS section on page 26 in your Samaritan Choice Plans' 2015 Medical & Pharmacy Benefits member handbook. 🡻 🡻 🡻

Hearing aids are covered up to $1,000 per calendar year for those on the Basic and Wellness Plan options. Members on the High Deductible Plan option have a $700 limit. Children do not have a hearing aid limit. These limits only apply to those 21 and over. Repairs or accessories to hearing aids will be paid through the annual limit. Batteries are not covered. Fittings and medically appropriate services for cochlear implants are covered.

🡻 🡻 🡻 This section replaces language in the BENEFIT EXCLUSIONS section on pages 32 and 33 in your Samaritan Choice Plans' 2015 Medical & Pharmacy Benefits member handbook. 🡻 🡻 🡻

This plan does not cover the following drugs and medications:

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

🡻 🡻 🡻 This section replaces language in the CLAIMS INFORMATION section on page 42 in your Samaritan Choice Plans' 2015 Medical & Pharmacy Benefits member handbook and on page 25 in your Samaritan Choice Plans' 2015 Vision Benefits member handbook.🡻 🡻 🡻

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. We will report this information to you on a form called an Explanation of Benefits. The Plan may pay claims, deny them, or accumulate them toward satisfying the Deductible. If the Claims Administrator denies all or part of a claim, the reason or reasons for the action will be stated in the Explanation of Benefits. The explanation will also contain the following items:

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

If the Covered Person receives payment for a benefit that he or she is not eligible to receive, the Plan has the right to recover the payment from the Covered Person (including by reducing future claim payments) or anyone else who benefits from it.

The 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.

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

- Samaritan Choice Plans, PO Box 336, Corvallis, OR 97339-0336

Claims that are submitted for an unidentified member will be returned to the provider. We cannot process a claim for someone that is not identified as a member under our plan and in our claims processing system.