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, 2016. If you do not have a 2015 Samaritan Choice Medical and Pharmacy Member Handbook, 2015 Samaritan Choice Vision Member Handbook, or your 2015 Summary of Material Modifications (SMM), 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 www.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 www.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.

Summary of benefits: Samaritan Choice Wellness Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Basic, Wellness and High-Deductible). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefit Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	**In Network: *Member Pays***	**Out of Network: *Member Pays***
PREVENTIVE SERVICES (these services are not applied to your deductible & some services will not have a cost share)		
Well baby care	$0	30%
Routine physicals	$0	30%
Routine gynecological exams	$0	30%
Immunizations	$0	30%
Colorectal screening	$0	30%
PROFESSIONAL SERVICES		
Primary care visits [1]	$20	30%
In-office procedures	$20	30%
Specialist visits	$35	30%
In-office procedures	$35	30%
Urgent care center visits	$20	$20
Surgery professional (at hospital or ASC)	$50	30%
PRIMARY CARE HOME (PCH) SERVICES *-In-Network WELLNESS PLAN Only.* All eligible services that are rendered and billed by assigned Primary Care Homes (PCH) are 100% covered by the Samaritan Choice Wellness Plan Option. Eligibility criteria will apply. 100% coverage only if the Wellness program identifies that the member would benefit from these services. You may be required to participate in these programs. No cost shares or deductibles apply.		
Primary Care Home (PCH) Services	$0	Not covered
CARE COORDINATION SERVICES - In Network providers only for asthma, diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD). No cost shares or deductibles apply.		
Office visit	$0	30%
EDUCATION SERVICES - In Network providers only. Regular cost-sharing is assessed for all out –of- network providers. Does not apply to deductibles.		
Office visit for specified education services	$0	30%
Heart Health and Wellbeing Program - In Network WELLNESS PLAN services only. All eligible services that are rendered and billed by assigned Program Coach are 100% covered only to those who are eligible for this Program. No cost shares or deductibles apply.		
Cardiac rehabilitation services	$0	Not covered
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	$100/day, up to 5 days or $500	30%
Inpatient rehabilitative care	$100/day, up to 5 days or $500	30%
Skilled Nursing Facility care	$0	30%
Bariatric surgery/ gastric banding (Lap band) surgery [2]	$5,000	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in office procedures)	$150	30%
Emergency department visits (unless admitted to hospital)	$100	$100
Radiology	$0	30%
Lab	$0	30%

Summary of benefits: Samaritan Choice Wellness Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Basic, Wellness and High-Deductible). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefit Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
VALUE-BASED COST SERVICES – In-Network only (Specified surgical procedures & high tech imaging)		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis) [3, 4]	$400 (does not apply to member OOP maximum or deductible)	30%
High tech imaging services [3, 4] (CT scans, MRIs and PET scans)	$200 (does not apply to member OOP maximum or deductible)	30%
CHEMICAL DEPENDENCY		
Office visits	$35	30%
Inpatient care	$100/day, up to 5 days or $500	30%
Residential programs	30%	30%
MENTAL HEALTH		
Office visits	$15	30%
Inpatient care	$100/day, up to 5 days or $500	30%
Residential programs	30%	30%
OTHER COVERED SERVICES		
Physical therapy	$25	30%
SHS Physical Therapist providers	$20	NA
Occupational therapy	$25	30%
Speech therapy	$25	30%
Allergy injections (most) [5]	$5	30%
Injectibles and other drugs administered other than orally (when rendered in the office) [5]	10%	10%
Ambulance, ground	30% after $100 co-pay	30% after $100 co-pay
Ambulance, air [6]	Plan pays up to $6,000 limit/incident	Plan pays up to $6,000 limit/incident
Durable Medical Equipment (DME)	30%	50%
Home health care	$15	30%
Hospice	$0	30%
Hearing aids	Plan pays up to $1,000 limit/year No limit for children age 20 and under	Plan pays up to $1,000 limit/year No limit for children age 20 and under
Acupuncture	$35	35%
Chiropractic [7]	$25, Plan pays up to $850 limit per year	30% Plan pays up to $850 limit per year
Panniculectomy [8]	50%	Not covered

[1] Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.
[2] Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit or deductibles.
[3] Value-based Co-pay does not apply if coded as Emergency Services. Cost shares will default to normal benefit for Emergency Services.
[4] Value-based co-pays do not count towards annual deductibles and Out-of-Pocket (OOP) Limits. Other applicable co-payment or coinsurance must be separately paid as applicable (e.g. office visits, lab services, etc.).
[5] Contact Customer Services at 541-768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance levels and applicable services.
[6] Air ambulance does not apply to Out-Of–Pocket (OOP) Limit.
[7] Chiropractic benefit only includes manipulation and exams. This benefit does not include x-rays, labs, other radiology or other services that are not considered to be a manipulation treatment.
[8] Panniculectomy coinsurance does not apply to Out-Of-Pocket Limit or deductible. Services will only be covered when gastric bypass has been rendered by contracted provider.

Summary of benefits: Samaritan Choice Basic Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Basic, Wellness and High Deductible Plans). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefit Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
PREVENTIVE SERVICES (these services are not applied to your deductible & some services will not have a cost share)		
Well baby care	$0	30%
Routine physicals	$0	30%
Routine gynecological exams	$0	30%
Immunizations	$0	30%
Colorectal screening	$0	30%
PROFESSIONAL SERVICES		
Primary care visits [1]	$30	30%
In-office procedures	$30	30%
Specialist visits	$40	30%
In-office procedures	$40	30%
Urgent care center visits	$30	$30
Surgery professional (at hospital or ASC)	$50	30%
CARE COORDINATION SERVICES In Network providers only for asthma, diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD). No cost shares or deductibles apply.		
Office visit	$0	30%
EDUCATION SERVICES In Network providers only. Regular cost-sharing is assessed for all out of network providers. Does not apply to deductibles.		
Office visit for specified education services	$0	30%
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	$200/day, up to 5 days or $1,000	30%
Inpatient rehabilitative care	$200/day, up to 5 days or $1,000	30%
Skilled Nursing Facility care	$0	30%
Bariatric surgery/ gastric banding (Lap band) surgery [2]	$5,000	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in office procedures)	$250	30%
Emergency department visits (unless admitted to hospital)	$100	$100
Radiology	10%	30%
Lab	10%	30%
VALUE-BASED COST SERVICES – In-Network only (Specified Surgical Procedures & High Tech Imaging)		
Specified surgical procedures [3, 4] (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis)	$500 (does not apply to member OOP maximum or deductible)	30%

Summary of benefits: Samaritan Choice Basic Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Basic, Wellness and High Deductible Plans). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefit Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	**In Network: *Member Pays***	**Out of Network: *Member Pays***
High tech imaging services [3, 4] (CT scans, MRIs and PET scans)	$200 (does not apply to member OOP maximum or deductible)	30%
CHEMICAL DEPENDENCY		
Office visits	$40	30%
Inpatient care	$200/day, up to 5 days or $1,000	30%
Residential programs	30%	30%
MENTAL HEALTH		
Office visits	$15	30%
Inpatient care	$200/day, up to 5 days or $1,000	30%
Residential programs	30%	30%
OTHER COVERED SERVICES		
Physical therapy	$25	30%
SHS Physical Therapist providers	$20	NA
Occupational therapy	$25	30%
Speech therapy	$25	30%
Allergy injections (most) [5]	$5	30%
Injectibles and other drugs administered other than orally (when rendered in the office) [5]	20%	20%
Ambulance, ground	30% after $100	30% after $100
Ambulance, air [6]	Plan pays up to $6,000 limit/incident	Plan pays up to $6,000 limit/incident
Durable Medical Equipment (DME)	30%	50%
Home health care	$15	30%
Hospice	$0	30%
Hearing aids	Plan pays up to $1,000 limit/year No limit for children age 20 and under	Plan pays up to $1,000 limit/year No limit for children age 20 and under
Acupuncture	$35	35%
Chiropractic [7]	$25, Plan pays up to $850 limit per year	30% Plan pays up to $850 limit per year
Panniculectomy [8]	50%	Not covered

[1] Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.

[2] Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit or deductibles.

[3] Value-based Co-pay does not apply if coded as Emergency Services. Cost shares will default to normal benefit for Emergency Services.

[4] Value-based co-pays do not count towards annual deductibles and Out-of-Pocket (OOP) Limits. Other applicable co-payment or coinsurance must be separately paid as applicable (e.g. office visits, lab services, etc.).

[5] Contact Customer Services at 541-768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance levels and applicable services.

[6] Air ambulance does not apply to Out-Of–Pocket (OOP) Limit.

[7] Chiropractic benefit only includes manipulation and exams. This benefit does not include x-rays, labs, other radiology or other services that are not considered to be a manipulation treatment.

[8] Panniculectomy coinsurance does not apply to Out-Of-Pocket Limit or deductible. Services will only be covered when gastric bypass has been rendered by contracted provider.

Summary of benefits: Samaritan Choice High Deductible Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Basic, Wellness and High-Deductible Plans). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefit Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
PREVENTIVE SERVICES (these services are not applied to your deductible & some services will not have a cost share)		
Well baby care	$0	30%
Routine physicals	$0	30%
Routine gynecological exams	$0	30%
Immunizations	$0	30%
Colorectal screening	$0	30%
PROFESSIONAL SERVICES		
Primary care visits [1]	$20	30%
In-office procedures	$20	30%
Specialist visits	$35	30%
In-office procedures	$35	30%
Urgent care center visits	$20	$20
Surgery professional (at hospital or ASC)	$50	30%
Office visit for specified education services	$0	30%
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	$100/day, up to 5 days or $500	30%
Inpatient rehabilitative care	$100/day, up to 5 days or $500	30%
Skilled Nursing Facility care	$0	30%
Bariatric surgery/ gastric banding (Lap band) surgery [2]	$5,000	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in office procedures)	$150	30%
Emergency department visits (unless admitted to hospital)	$100	$100
Radiology	$0	30%
CT, PET scan	$0	30%
MRI	$150	30%
Lab	$0	30%
MENTAL HEALTH		
Office visits	$35	30%
Inpatient care	$100/day, up to 5 days or $500	30%
Residential programs	30%	30%
CHEMICAL DEPENDENCY		
Office visits	$35	30%
Inpatient care	$100/day, up to 5 days or $500	30%
Residential programs	30%	30%

Summary of benefits: Samaritan Choice High Deductible Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Basic, Wellness and High-Deductible Plans). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefit Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	**In Network: *Member Pays***	**Out of Network: *Member Pays***
OTHER COVERED SERVICES		
Physical therapy	$25	30%
SHS Physical Therapist providers	$20	NA
Occupational therapy	$25	30%
Speech therapy	$25	30%
Allergy injections (most) [3]	$5	30%
Injectibles and other drugs administered other than orally (when rendered in the office) [3]	10%	10%
Ambulance, ground	30% after $100 co-pay	30% after $100 co-pay
Ambulance, air [4]	Plan pays up to $6,000 limit/incident	Plan pays up to $6,000 limit/incident
Durable Medical Equipment (DME)	30%	50%
Home health care	$15	30%
Hospice	$0	30%
Hearing aids	Plan pays up to $700 limit/year No limit for children age 20 and under	Plan pays up to $700 limit/year No limit for children age 20 and under
Acupuncture	$35	35%
Panniculectomy [5]	50%	Not covered

[1] Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.
[2] Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit or deductible.
[3] Contact Customer Services at 541-768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance levels and applicable services.
[4] Air ambulance does not apply to Out-Of–Pocket (OOP) Limit.
[5] Panniculectomy coinsurance does not apply to Out-Of-Pocket Limit or deductible. Services will only be covered when gastric bypass has been rendered by contracted provider.

Samaritan Choice Plans
2016 PRIOR AUTHORIZATION LIST

Coverage of certain medical services and surgical procedures require Samaritan Choice Plans' (SCP) written authorization before the services are performed. 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. In some cases, additional information or a second opinion may be required before authorizing coverage.

THE FOLLOWING MEDICAL SERVICES AND SURGICAL PROCEDURES REQUIRE PRIOR AUTHORIZATION BY SAMARITAN CHOICE PLANS:

- Clinical trials that are considered experimental
- Durable Medical Equipment (DME) including insulin pumps, prosthesis, oxygen and oxygen supplies, with line item prices over $1,000 in rental or purchase fees or rentals over 3 months.
    - Continuous Glucose Monitors (CGM) and CGM supplies
- Elective procedures or services (for the following):
    - Bariatric surgery
    - Genetic testing except standard prenatal testing, which includes Verifi®
    - Neck and back surgery (inpatient, outpatient and those done as in-office procedures)
    - Panniculectomy
    - Sclerotherapy
    - Uvulopalatopharyngoplasty
- Inpatient hospital care*, including:
    - Exception of maternity delivery services*
    - Hospitalization for dental procedures
    - Mental health services
- Potentially cosmetic, reconstructive and/or experimental surgery and services
- Radiological services (for the following):
    - Capsule/wireless endoscopies
    - Computer Axial Tomography (CAT) scans
    - Magnetic Resonance Imaging (MRI)
    - Positron Emission Tomography (PET) scans
    - Virtual Colonoscopy
- Residential services for mental health and substance abuse treatment including detoxification
- Skilled Nursing Facility (SNF)
- Therapeutic abortion
- Transplants, including evaluation (except corneal)

*Inpatient hospitalization admissions for the purpose of childbirth does not require a prior authorization in accordance with the Newborns' and Mothers' Protections (Newborns' Act). Services do not require prior authorization unless hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. Emergency Services will not require prior authorization in accordance with Patient Protection and Affordability Care Act. We request notification of any emergency admissions or observation stays that exceed 48 hours in order to ensure that all of the member's care is appropriately coordinated.

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

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

For these purposes, "generally accepted standards of medical practice" means standards based on credible scientific evidence that is 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.

Samaritan Choice Plans reserves the right to review or otherwise deny services that are not medically necessary. Prior authorization is not guarantee of payment.

⬇ ⬇ ⬇ THIS SECTION REPLACES LANGUAGE IN THE DEFINITONS SECTION ON PAGE 3 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK AND ON PAGE 3 IN YOUR SAMARITAN CHOICE PLANS' 2015 VISION BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

Professional provider: Licensed or Registered Medical Providers that provide Medically Necessary covered services within the scope of their license or registry. The term "Professional Provider" does not include a naturopath, a massage therapist or any other class of provider not covered by the Plan.

⬇ ⬇ ⬇ 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 ⬇ ⬇ ⬇

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.

⬇ ⬇ ⬇ THIS SECTION REPLACES LANGUAGE IN THE PLAN BENEFITS SECTION ON PAGE 24, 25 AND 28 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

Chiropractic services are covered up to $850 a year for manipulations and exams only for those members on the Wellness and Basic Plan options. Manipulations are covered; x-rays and labs are not covered under this benefit. Any supplies or DME items provided during the visit will be **considered** under that benefit and may have additional cost.

Developmental and learning disabilities Services will be covered for developmental and/or learning disabilities in the absence of illness, or when it is medically necessary.

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

- Pervasive developmental disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability, or mental retardation. This does not include educational delays in mathematics, reading, or any school development.
- **Autism will be a covered benefit up to 25 visits for occupational, speech, and physical therapy.**

Physical therapy direct access physical therapy services of licensed Physical therapists for physical therapy are covered. This service does not require a physician referral; members may self-refer.

SamFit conditioning and training option When a Samaritan Physical Therapist refers a member for SamFit training and conditioning, in accordance to the criteria below, the member may have up to 3 months of a SamFit gym membership paid at one time. **Members can also be referred to the Samaritan Athletic Medicine center (SAM) for the training and conditioning.**

- Member must benefit from physical conditioning to support the member's recovery of the condition treated, while reducing the risk of a reoccurrence.
- The member must require additional assistance in performing specific rehabilitative exercises, so that further injuries can be avoided.

Additional services may be reimbursed through additional review and referral of a Samaritan Physical Therapist supporting that the members meet 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 through the SamFit locations and appropriate staff where required. This benefit is specific to Samaritan Choice Plans and is not a benefit that can be coordinated between multiple plan coverage. This benefit applies to all members on the Samaritan Choice Plan. The SamFit benefit does not apply to your deductible.

Education services this benefit, previously called Education and Coaching services, is $0 co-pay for office visits for *Education services* opened to any In Network Provider. Regular cost sharing remains for non-preferred providers.

⬇ ⬇ ⬇ THIS LANGUAGE WAS ADDED TO THE PLAN DISCLOSURES SECTION ON PAGES 42-44 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK AND ON PAGES 19-20 IN YOUR SAMARITAN CHOICE PLANS' 2015 VISION BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

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 a FMLA leave for up to a maximum of 12 work-weeks within a 12-month period for the following reasons:

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

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 (see Continuation coverage section) qualifying event unless coverage is reinstated at the end of the leave. If the employee chooses to continue coverage while on an approved FMLA leave, he or she may do so by paying any required contribution rates that would have been paid by payroll deduction if they had been working. All contributions are due the first of each month, and if the employee fails to pay any required contribution, coverage will terminate on the last day of the month that contributions were paid.

If the employee returns to active employment after an entitled FMLA leave, group coverage will be reinstated. Waiting periods satisfied prior to an employee's approved leave would be reinstated when an employee returns to work. This is true even if coverage was terminated due to lapse of contribution payments on the employee's part. Benefits will be restored to the benefits 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 an 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 your own or a relative's serious health condition, or another circumstance beyond your control), SHS has the right to recover contributions it paid during the leave. If the employee does not return from a FMLA leave, health coverage will cease and a COBRA qualifying event will occur on the earlier of the:

- end of the leave period, OR
- day the Employer learns the employee does not plan to return.

Also, Oregon has a family leave law that has been revised to substantially parallel the federal FMLA law. However, there are a few provisions that differ between the Oregon Leave law and FMLA. Please contact the Human Resources office for details on the policies and procedures of these laws and to obtain the required leave request forms.

Oregon Family Leave Act (OFLA)

OFLA covered employer (25-49 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 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. House Bill 2600 aligns OFLA with FMLA's continuation of group health insurance coverage.

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; or
- 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).

Leave of absence: If you are granted an approved non-FMLA or USERRA leave of absence, you can arrange to continue coverage for yourself and your family for up to three months. You must continue any premium contribution payments you were making prior to the leave.

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

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health 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 insurance coverage through the Health Insurance Marketplace. For more information, visit **www.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.
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml
Call: 1-888-564-9669

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, contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.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 www.askebsa.dol.gov.

MICHELLE's Law (P.L. 110-381)

Effective January 1, 2010, eligible dependents are allowed to continue coverage under a Health Plan when a medically necessary change to part time student status or leave of absence from a post-secondary educational institution is required. Please refer to the following guideline and definitions.
A dependent child is, a beneficiary under the plan who:

- Is a dependent child, under the terms of the plan, of a participant or beneficiary under the plan; and,
- Was enrolled in the plan, on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.
- A medically necessary leave of absence in connection with a group health plan, is a leave of absence of the dependent child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:
    - Commences while such child is suffering from a serious illness or injury;
    - is medically necessary; and
    - causes such child to lose student status for purposes of coverage under the terms of the plan.

Samaritan Choice Plans will not terminate coverage of a dependent child under the plan due to a medically necessary leave of absence before the date that is the earlier of:

- the date that is one (1) year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan.

To qualify for this exception the medically necessary leave of absence or change to part time student status will need to be certified by a physician as follows:

A written certification by a treating physician, of the dependent child, which states that the child is suffering from a serious illness or injury, and that the leave of absence (or other change of enrollment) described is medically necessary must be provided to Human Resources. To obtain more information please contact your designated Human Resources Department.

WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].
If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

The Newborns' and Mothers' Health Protection Act of 1996

Under federal law, this 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. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

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 Samaritan Choice Plans. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to Samaritan Choice Plans on January 1, 2011.
For more information contact Samaritan Choice Plans administrators at 541-768-4550 or 1-800-832-4580.

⬇ ⬇ ⬇ THIS LANGUAGE WAS ADDED TO THE PLAN ADMINISTRATION SECTION STARTING ON PAGE 50 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

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 at [insert contact information] 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.

Samaritan Choice Plans
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www.myhealthplan.samhealth.org