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, 2018. If you do not have a 2015 Samaritan Choice Medical and Pharmacy Member Handbook, 2015 Samaritan Choice Vision Member Handbook, or your 2015, 2016, and 2017 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 MyHealthPlan.samhealth.org.

KEEP THIS NOTICE WITH YOUR 2015, 2016, and 2017 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 and Pharmacy and your Vision plan documents. All plan documents are available online at choice.samhealthplans.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 (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 Benefits and 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 and 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]	$25	30%
In-office procedures	$25	30%
Specialist visits	$40	30%
In-office procedures	$40	30%
Urgent care center visits	$40	$40
Surgery professional (at hospital or ASC)	$60	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 – For asthma, diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD).		
Office visit	$0	30%
EDUCATION SERVICES		
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 (SHS facility)	$175/day, up to 5 days or $875	NA
Inpatient room and board (non-SHS facility)	$300/day, up to 5 days or $1,500	30%
Inpatient rehabilitative care (SHS facility)	$175/day, up to 5 days or $875	NA
Inpatient rehabilitative care (non-SHS facility)	$300/day, up to 5 days or $1,500	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) (SHS facility)	$150	NA

Summary of Benefits: Samaritan Choice Wellness Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (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 Benefits and Coverage document. Important Notice: All services apply to the deductible unless otherwise specified.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
OUTPATIENT SERVICES (continued)		
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	$250	30%
Emergency department visits (unless admitted to hospital)	$150	$150
Radiology	$25	30%
Lab	$0	30%
VALUE-BASED 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	$40	30%
Inpatient care (SHS facility)	$175/day, up to 5 days or $875	NA
Inpatient care (non-SHS facility)	$300/day, up to 5 days or $1,500	30%
Residential programs	30%	30%
MENTAL HEALTH		
Office visits	$25	30%
Inpatient care (SHS facility)	$175/day, up to 5 days or $875	NA
Inpatient care (non-SHS facility)	$300/day, up to 5 days or $1,500	30%
Residential programs	30%	30%
OTHER COVERED SERVICES		
Physical therapy	$35	30%
SHS Physical Therapy providers	$30	NA
Occupational therapy	$35	30%
Speech therapy	$35	30%
Allergy injections (most) [5]	$15	30%
Injectables and other drugs administered other than orally (when rendered in the office) [5]	20%	20%
Ambulance, ground	30% after $100 co-pay	30% after $100 co-pay
Ambulance, air [6]	30%	30%
Durable Medical Equipment (DME)	30%	50%
Home health care	$30	30%
Hospice	$0	30%

Summary of Benefits: Samaritan Choice Wellness Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (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 Benefits and 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 (continued)		
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 Pediatric, Family Medicine, 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 copay does not apply if coded as Emergency Services. Cost shares will default to normal benefit for Emergency Services.
[4] Value-based copays do not count towards annual deductibles and Out-of-Pocket (OOP) Limits. Other applicable copay 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 copay 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 (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 Benefits and 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 and 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%
EDUCATION SERVICES		
Office visit for specified education services	$0	30%

Summary of Benefits: Samaritan Choice High-Deductible Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (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 Benefits and Coverage document. Important Notice: All services apply to the deductible unless otherwise specified.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
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%
OTHER COVERED SERVICES		
Physical therapy	$25	30%
SHS Physical Therapy providers	$20	NA
Occupational therapy	$25	30%
Speech therapy	$25	30%
Allergy injections (most) [3]	$5	30%
Injectables 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]	30%	30%
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

Summary of Benefits: Samaritan Choice High-Deductible Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (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 Benefits and 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 (continued)		
Acupuncture	$35	35%
Panniculectomy 5	50%	Not covered

[1] Primary Care Provider visit is defined as services provided by a Pediatric, Family Medicine, and Internal Medicine or OB-GYN provider.
[2] Bariatric Surgery and Gastric Banding (Lap band) surgery copays 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 copay 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.

Prescription Drug Summary of Benefits

Tier 1 - Therapeutic and Preventive	Tier 2 - Preferred Generic	Tier 3 - Preferred Brand	Tier 4 - Non-Preferred	Tier 5 - High-Cost Specialty
$0 for: • 9 specified generic drugs • Selected asthma medications • Tobacco cessation drugs/supplies • Diabetic insulin, syringes, and needles	$7 or 20% whichever is greater	$25 or 25% whichever is greater	50%	10%

Tier 1 – Therapeutic and Preventive Tier offers a $0 copay for nine generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, enalapril, atenolol and warfarin. Tobacco cessation and asthma medications are included. Zero ($0) cost share for diabetic administration of insulin, includes needles and syringes.

Tier 2 – Preferred Generic Drugs provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost. You will pay a $7 copay or 20% coinsurance, whichever is greater, when you use generic drugs.

Tier 3 – Preferred Brand Drugs, in most cases brand name drugs provide high quality, effective and affordable prescription benefits to Samaritan Choice Plans members. Preferred drugs are either more effective or equally effective, but less costly than other alternative medications not included on the preferred drug list. They are often the preferred agent in a class of medications that has many alternatives and will treat most health conditions. You will pay a $25 copay or 25% coinsurance, whichever is greater, when you use preferred brand drugs.

Tier 4 – Non-Preferred Drugs are available generically, and it is your choice to receive brand name rather than the therapeutic generic equivalent. You will pay 50% of the cost of drugs in this tier. If your medication is categorized as a Tier 4 medication and does not have an equivalent generic available, you may request a tier exception for your medication to be paid at Tier 3 as long as the medication is listed on the formulary and does not require a prior authorization.

Tier 5 – High-Cost Specialty Medications encompass specified medications. This category is subject to change, throughout the year, upon review by the SCP Pharmacy and Therapeutics Committee. Your coinsurance is equal to 10% of the cost of these drugs. You may be charged this coinsurance if the medication is received in another setting (for example, infusion).

⬇ ⬇ ⬇ THIS SECTION REPLACES LANGUAGE IN THE OUT-OF-POCKET LIMITS AND DEDUCTIBLES SECTION ON PAGES 4-5 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

Out-of-Pocket limits and deductibles

This is only a brief summary of benefits. Please refer to the additional information throughout this Plan Document for further explanations of your benefits including limitations and exclusions.

Out-of-Pocket limits

Samaritan Choice Wellness Plan	Your Out-of-Pocket max
Per member	$3,000
Per family	$6,000
Samaritan Choice High-Deductible Plan	**Your Out-of-Pocket max**
Per member	$3,150
Per family	$6,300
Samaritan Choice Pharmacy	**Your Out-of-Pocket max**
Per member	$4,200
Per family	$8,400

There is no Out-of-Pocket limit for non-preferred providers.

Your annual Out-of-Pocket Limit

This plan has an out-of-pocket limit to protect you from excessive medical expenses. The Summary of Benefits shows your plan's annual out-of-pocket limit. 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 those benefits.

Expenses for the following DO NOT count toward your Out-of-Pocket Limit:

- Prescription drugs (separate out-of-pocket limit applies)
- Charges over usual, customary, and reasonable amounts
- Air ambulance
- Benefits paid in full (for example, vision hardware)
- Incurred charges that exceed amounts allowed under this plan
- Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan
- Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims)
- Bariatric and Gastric banding surgery co-pays
- Value-based service co-pays
- Panniculectomies
- Other services that are specifically called out in this document

Samaritan Choice Wellness Plan:

Out-of-Pocket max

- Preferred providers: $3,000 per person/ $6,000 per family per calendar year.

- Non-Preferred providers: Unlimited.
- Once the applicable out-of-pocket limit has been met, this plan will pay 100% of covered charges for services at the applicable preferred benefit level for the rest of that calendar year.
- The pharmacy benefit has a separate out-of-pocket limit of $4,200 per person and $8,400 per family.

Samaritan Choice High-Deductible Plan:

Out-of-Pocket max

- Preferred providers: $3,150 per person/ $6,300 per family per calendar year.
- Non-Preferred providers: Unlimited.
- Once the applicable out-of-pocket limit has been met, this plan will pay 100% of covered charges for all services at the applicable preferred benefit level for the rest of that calendar year.
- The pharmacy benefit has a separate out-of-pocket limit of $4,200 per person and $8,400 per family.

Information about your deductible

Deductible. This is the portion of covered benefit costs each member is obligated to pay before Samaritan Choice Plans will provide benefits. The deductible amount for individuals and families is listed in your Member Benefit Summary. No family will have to satisfy more than the Family Maximum Deductible each calendar year.

The following DO NOT count toward deductible:

- SOME preventive services do not apply to your deductible obligation.
- Bariatric surgery/services
- Value based service co-pays
- Panniculectomies
- Other services outlined in this document

Plan	Maximum lifetime benefit	Annual individual deductible	Annual family deductible
Wellness Plan option	None	$300	$900
High-Deductible Plan option	None	$2,500	$7,500
Your Preferred and Non-preferred deductibles are combined.			

⬇ ⬇ ⬇ THE LANGUAGE IN THIS BENEFIT REPLACES LANGUAGE IN THE PLAN BENEFITS SECTION ON PAGE 23 AND PAGES 28-29 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

Ambulance services of a state-certified ambulance. Air transportation is also covered, but only to the nearest hospital capable of treatment, when ground transportation is inappropriate, and when medically necessary. Please refer to the Summary of Benefits schedule for additional reimbursement information on this benefit. The allowable for any medically appropriate air ambulance service received from a nonparticipating provider will be reimbursed at up to 250% of the Medicare allowable. Please be aware that services provided by any nonparticipating provider are likely to be costlier than those you would receive from a participating provider, and your cost share may be higher. The nonparticipating provider may also choose to balance bill you for any amount not paid by this Plan.

Prescription drug services

In addition to the definitions found in the Definitions section, the following are definitions of some important terms used under this benefit:

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. 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 Samaritan Choice Plans.

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

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

Therapeutic tier. This tier includes generic drugs that are intended to control selected medical conditions that have been targeted by Samaritan Health Plans. The Therapeutic tier offers a $0 copay for nine generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, enalapril, atenolol and warfarin.

Tobacco cessation and asthma medications are included as well as diabetic insulin, needles, and syringes.

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 which includes:

- Elm Street Pharmacy – Albany
- Geary Street Pharmacy – Albany
- Samaritan Pharmacy Services – Corvallis
- Samaritan Lebanon Outpatient Pharmacy – Lebanon
- Samaritan Pacific Communities Hospital Pharmacy – Newport
- Samaritan North Lincoln Hospital Pharmacy (Urgent Needs Only) – Lincoln City
- Or at any Walgreens pharmacy nationwide

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 on which tier a specific drug is categorized in. Samaritan Choice Plans 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 medications are covered with an approved prior authorization.

Prescription formulary. The medications listed in the formulary are subject to change. The presence of a medication in the formulary does not guarantee that you as a plan member will be prescribed that drug by your primary care physician or contracting provider for a particular medical condition. The medications 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 medications listed on the Samaritan Choice Formulary found at choice.samhealthplans.org. Developed in collaboration with Samaritan Choice Plans, physicians and pharmacists, the formulary includes FDA-approved prescription generic, brand name, and specialty medications. The formulary can help you and your physician choose effective, quality medications to minimize your out-of-pocket expense.

Formulary updates

The formulary is updated at minimum on a quarterly basis. Samaritan Choice Plan 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 Plan prescription drug coverage will not change during the year unless:

- The medication becomes available in generic form;
- There are safety or effectiveness concerns raised about the prescription drug; or
- The Pharmacy and Therapeutics committee determines that changes to the formulary would be in the best overall interest of Samaritan Choice Plan members.

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

- Tier 1 – Therapeutic and Preventive Tier offers a $0 copay for nine generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, enalapril, atenolol and warfarin. Tobacco cessation and asthma medications are included as well as diabetic insulin, needles, and syringes.
- Tier 2 – Preferred Generic Drugs provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost. You will pay a $7 copay or 20% coinsurance, whichever is greater, when you use generic drugs.
- Tier 3 – Preferred Brand Drugs, in most cases Brand drugs, provide high quality, effective and affordable prescription benefits to Samaritan Choice Plans members. Preferred drugs are either more effective or equally effective, but less costly than other alternative medications not included on the preferred drug list. They are often the preferred agent in a class of medications that has many alternatives and will treat most health conditions. You will pay a $25 copay or 25% coinsurance, whichever is greater, when you use preferred brand drugs.
- Tier 4 – Non-Preferred Drugs are available generically, and it is your choice to receive brand name rather than the therapeutic generic equivalent. You will pay 50% of the cost of drugs in this tier. If your medication is categorized as a Tier 4 medication and does not have an equivalent generic available, you may request a tier exception for your medication to be paid at Tier 3 as long as the medication is listed on the formulary and does not require a prior authorization.
- Tier 5 – High-cost specialty medications encompass specified medications. This category is subject to change, throughout the year, upon review by the SCP Pharmacy and Therapeutics Committee. Your coinsurance is equal to 10% of the cost of these drugs. You may be charged this coinsurance if the medication is received in another setting (for example, infusion).

Please note: SCP will only cover medications up to a ninety (90) day supply, even when medications 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 choice.samhealthplans.org or contact Pharmacy Services at 541-768-4550 or toll free 1-800-832-4580.

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 drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your medication exception request.

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

Allow for a 90-day transition period on selected non-formulary Mental Health and behavioral drugs. For more information contact 541-768- 4550 or toll free 1-800-832-4580 as this list is regularly updated as new medications and generics become available.

Prescription urgent and emergent prescription drugs can be filled at any Samaritan Health Services pharmacy or Walgreens pharmacy. 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 us to reimburse you for our share of the cost. If you utilize an out-of-network pharmacy during an urgent or emergent situation, this 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 Reimbursement Claim form to the Claims Administrator for payment consideration. Forms for submitting these claims are online at choice.samhealthplans.org.

Each claim is reviewed by the 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.

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 Reimbursement Claim form to the Claims Administrator for payment. Forms for submitting these claims are available online at choice.samhealthplans.org.

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 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.

Prescription out-of-pocket maximum. The maximum out of pocket on prescription drugs is $4,200 for individuals and $8,400 out-of-pocket maximum limit for families. This is in addition to the out-of-pocket maximum for medical services. If the individual $4,200 prescription drug out-of-pocket maximum has been reached or if the member has double coverage through Samaritan Choice for prescription expenditures, a $30 copay will apply, per prescription drug, when the member chooses not to use the drug that is therapeutically equivalent and available in a lower Tier.

🡻 🡻 🡻 THIS SECTION REPLACES LANGUAGE IN THE PRIOR AUTHORIZATION SECTION ON PAGE 34 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

2018 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. This requirement applies to both Preferred and Non-Preferred Providers. Failure to obtain a prior authorization may result in your claim being denied, either in whole or in part. In some cases, SCP may require you to provide additional information or seek a second opinion before authorizing coverage.

Prior authorization by Samaritan Choice Plans is required for the following medical services and surgical procedures:

- Clinical Trials
- 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 and Non-Invasive Prenatal Testing (NIPT)
    - Neck and back surgery (inpatient, outpatient and those done as in-office procedures)
    - Panniculectomy
    - Sclerotherapy
    - Uvulopalatopharyngoplasty
- Hospitalization for dental procedures including ASC
- Inpatient hospital care*, including:
    - Mental health services
    - Exception: Labor and delivery
    - Exception: Newborn less than 5 days
- Potentially cosmetic, reconstructive and/or experimental surgery and services
- Radiological services (for the following):
    - Capsule/wireless endoscopies
    - Computer Axial Tomography (CAT) scans, except with participating provider
    - CT Scan Thorax; w/o contrast (CPT Code 71250)
    - Low Dose CT Scan (LDCT) for lung cancer screening (Code G0297)
    - 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)
- Unlisted procedure codes

* 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.

Prior authorization by Samaritan Choice Plans is required for the following drugs when paid under the medical plan:

- Abatacept
- Abobotulinumtoxin A
- Afibercept
- Agalsidase Beta
- Albiglutide
- Alemtuzumab
- Alglucosidase Alfa
- Alpha-1 Proteinase Inhibitor
- Ambrisentan
- Anakinra
- Antibiotics, Inhaled
- Antihemophilic Factor
- Aprepitant and Fosaprepitant
- Becaplermin
- Belatacept
- Belimumab
- Bevacizumab
- Bortezomib
- Bosentan
- C1 Esterase Inhibitor
- Certolizumab
- Cetuximab
- Coagulation Factor IX
- Coagulation Factor VIIa
- Cobimetinib
- Collagenase, Injectable
- Crizotinib
- Daclatasvir
- Daratumumab
- Denosumab
- Dimethyl Fumarate
- Dornase Alfa
- Eculizumab
- Edetate (EDTA) Chelation
- Epoprostenol
- Epoetin and Darbepoetin
- Etanercept
- Fingolimod
- Fulvestrant
- Glatiramer Acetate
- Golimumab
- Gonadotropin-releasing Hormone (GnRH) Agonists
- Granulocyte Colony-Stimulating Factor (G-CSF) or Granulocyte-Macrophage Colony-Stimulating Factor (GM-CSF)
- Hyaluronic Acid, Intra-articular Injection
- Icatibant
- Idursulfase
- Iloprost
- Imiglucerase
- Immune Globulin Intravenous (IVIG)
- Infliximab
- Interferon and Peginterferon
- Ipilimumab
- Lanreotide
- Laronidase
- Ledipasvir-Sofosbuvir
- Mecasermin
- Mepolizumab
- Miglustat
- Natalizumab
- Nivolumab
- Romiplostim
- Octreotide
- Omalizumab
- OnabotulinumtoxinA
- Oprelvekin
- Palifermin
- Palivizumab
- Palonosetron
- Panitumumab
- Pasireotide
- Pegaptanib
- Pegloticase
- Pegvisomant
- Pembrolizumab
- Pertuzumab
- Ranibizumab
- RimabotulinumtoxinB
- Rituximab
- Secukinumab
- Simeprevir
- Skin Substitute, Tissue-Engineered
- Sofosbuvir
- Somatropin
- Taliglucerase
- Teduglutide
- Teriflunomide
- Teriparatide
- Tocilizumab
- Trastuzumab
- Treprostinil
- Unlisted drug codes
- Ustekinumab
- Vedolizumab
- Velaglucerase
- Vemurafenib

🡻 🡻 🡻 THIS LANGUAGE WAS ADDED TO THE GENERAL PROVISIONS SECTION ON PAGE 36 IN YOUR 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

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 plan document, to any other person, corporation, or other organization or entity.

⬇ ⬇ ⬇ THIS SECTION REPLACES LANGUAGE IN THE MEMBER GRIEVANCES AND APPEALS PROCESS SECTION ON PAGES 39-41 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

Member Grievances and Appeals Process

Authorized representative

You or someone you name to act on your behalf (Authorized Representative) may file a verbal or a written grievance, and/or you can appeal in writing with Samaritan Choice Plan (SCP).

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

Please note: In order for SCP to process a request received from your Authorized Representative, we must have proof of such designation; such as, a signed representative form; other appropriate legal papers supporting an authorized representative's status or a Durable Power of Attorney document.

SCP has an Authorized Representative form that you can request by calling our Customer Service Department at 541-768-4550 or toll free at 1-800-832-4580 or TTY/TTD 1-800-735-2900.

Filing a grievance

Grievance means a verbal or written complaint regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the Plan through a prior authorization; or
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between the member and the Plan.

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

Upon receiving a grievance, we will send you or your Authorized Representative an acknowledgment letter. If the grievance cannot be resolved within five business days of receipt, we will notify you in writing that additional time is required. You or your Authorized Representative will then receive a written decision within 30 days from your initial call or letter.

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; and 4) received by us 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 five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter.

The Internal appeal decision will be determined by an appropriate healthcare professional not previously involved in your case.

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.

Please note: If you, your Authorized Representative or your treating provider believes that the request to appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, your appeal will be processed in an expedited manner (72 hours of our receiving the appeal). Only pre-service requests qualify for expedited processing.

Urgent is determined when the member's health or life 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.

External review

You, your Authorized Representative or your treating provider may request a simultaneous expedited External Review.

For more information, please refer to the Expedited appeal section.

If you are still dissatisfied with our final adverse determination, your appeal may qualify for an External Review (at no cost to you) if:

- The Plan does not adhere to the rules and guidelines of the process defined for the Internal review;

OR

- The Internal review has been completed; and, the reason for the adverse decision was:
  - based on medical necessity; or,
  - for treatment determined to be experimental or investigational; or,
  - for the purpose of continuity of care;

OR

- You and the Plan have mutually agreed to waive the internal appeal requirement.

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

To apply for an External Review you must send your written request or the Appeal Request Form to us at the following address:

Samaritan Choice Plans- Appeal Team
P.O. Box 1310
Corvallis, Oregon 97339

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 5 business days. You will receive a letter from the IRO informing you that your request for External Review has been received. You will have 10 business days to submit additional information directly to the IRO.

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

- Expedited External Review - 72 hours after receipt of the request
- Standard External Review - 45 days after receipt of the request

IRO decisions are final and we are bound by their decisions. If you want more information regarding External Review, please contact our Customer Service Department at 541-768-4550; toll-free at 1-800-832-4580 or TTY 1-800-735-2900.

Expedited appeals

Urgent is determined when the member's health or life 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 72 hours of our receiving the appeal 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,
  and
- state the reason for the appeal request;
  and
- state the reason an expedited decision is needed;
  and
- include supporting documentation necessary for the Plan to make a decision.

The Internal Expedited review decision will be determined by an appropriate healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative and your treating provider as soon as possible but no later than 72 hours of our receiving the appeal. 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 72 hours 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 or the Appeal Request Form to:

Samaritan Choice Plans Appeal Team
P.O. Box 1310
Corvallis, Oregon 97339
Fax to: 541-768-9765

Call our Customer Service Department:

541-768-4550, toll free 1-800-832-4580
or TTY 1-800-735-2900

APPEAL TIMELINES

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

- 72 hours 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 our Customer Service Department at: 541-768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900, OR online at: choice.samhealthplans.org.

- Authorized Representative
- Appeal Request
- Authorization to Disclose Health Plan Records

Your appeal rights

You have the right to:

- File a grievance about and appeal any decision we make regarding availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the Plan through a prior authorization, claims payment, handling or reimbursement for healthcare 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 Benefit 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 72 hours 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 72 hours 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 health or life 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:

Call our Customer Service Department:
541-768-4550; toll-free at 1-800-832-4580 or
TTY 1-800-735-2900.

Or

Write to:
Samaritan Choice Plans– Appeals Team
P.O. Box 1310
Corvallis, Oregon 97339

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:

Department of Consumer and Business Services
350 Winter Street NE
PO BOX 14480
Salem, OR 97309-0405
Email: dcbs.director@state.or.us

U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Ave., N.W.
Washington, D.C. 20210

🡻 🡻 🡻 THIS SECTION REPLACES LANGUAGE IN THE YOUR MEMBER RIGHTS AND RESPONSIBILITIES SECTION ON PAGE 42 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

Your Member Rights and Responsibilities

Your RIGHTS as a member:

- You have a right to receive information about Samaritan Choice Plans, 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 healthcare 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 Samaritan Choice Plans or the care you receive, and to appeal decisions you believe are wrong.

Your RESPONSIBILITIES as a member:

- You are responsible for providing Samaritan Choice Plans 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 healthcare 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.

🡻 🡻 🡻 THIS LANGUAGE REPLACES LANGUAGE IN THE PLAN DISCLOSURES SECTION ON PAGES 42-49 OF YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

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 Plan document. You may access your Plan document online at choice.samhealthplans.org.

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 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 (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)

An 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.

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 1-866-4-USA-DOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- 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.

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 copays, 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 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://healthcare.oregon.gov/Pages/index.aspx
Call: 1-800-699-9075

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 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the 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 or call 1-866-444-EBSA (3272).

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 certified by a physician as being 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.

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

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

WHCRA full annual notice

The Women's Health and Cancer Rights Act of 1998 requires Samaritan Health Services to notify you, as a participant or beneficiary of the Samaritan Choice Plans, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

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

These benefits are subject to the plan's regular deductible and copays/coinsurance. See SUMMARY OF BENEFITS for details.

Keep this notice for your records and call your Plan Administrator, Samaritan Choice Plans, 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 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 Samaritan Choice Plans. Individuals may request enrollment for such children for 30 days from the date of notice. For more information contact Samaritan Choice Plans administrators at 541-768-4550 or 1-800-832-4580.

Lifetime Limit and Enrollment Opportunity Notice (PPACA, 2010)

The lifetime limit on the dollar value of benefits under Samaritan Choice Plans 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 contact Samaritan Choice Plans administrators at 541-768-4550 or 1-800-832-4580.

Patient Protections Notice (PPACA, 2010)

Samaritan Choice Plans 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, contact Samaritan Choice Plans administrators at 541-768-4550 or 1-800-832-4580.

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

You do not need prior authorization from Samaritan Choice Plans 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, contact Samaritan Choice Plans administrators at 541-768-4550 or 1-800-832-4580.

*Primary Care Provider is defined under Samaritan Choice Plans provisions as a Pediatric, Family Medicine, Internal Medicine or OB-GYN provider.

Statement of ERISA Rights

As a participant in this welfare benefits Plan, 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, 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 Plan document 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, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Certificate of creditable coverage

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

Rights to receive certificates

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

Automatic provision of certificate

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

In the case of a Covered Person who has elected COBRA continuation coverage, a certificate of creditable coverage will automatically be provided to the Covered Person within a reasonable time after the date such continuation coverage ends. In the event that such continuation coverage ends because of the non-payment of the required continuation coverage premium payments, then the certificate will be provided within a reasonable time after the end of any applicable payment grace period.

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

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

Samaritan Health Plan Operations:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Denise Severson at 541-768-4550, TTY: 1-800-735-2900.

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

Denise Severson, Compliance Manager/Officer PO Box 1310
Corvallis, OR 97339
541-768-4550, TTY: 1-800-735-2900, Fax: 541-768-9791
dseverson@samhealth.org

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

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD).

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

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the use and disclosure of your medical information by Samaritan Health Plan Operations (SHPO), which includes:

- InterCommunity Health Network Coordinated Care Organization (IHN-CCO)
- Samaritan Advantage Health Plans (SAHP)
- Samaritan Choice Plans
- Samaritan Employer Plans

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that your health and medical information is personal, and we are committed to protecting your medical information.

This notice describes the ways in which we may use and disclose medical information about you. We also describe your rights and the obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose medical information about you for treatment activities. We may disclose medical information about you to doctors, nurses, technicians, medical and paramedical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments share medical information about you in order to coordinate the different things you need, such as prescriptions and medical supplies or services. We also may disclose medical information about you to those who may be involved in your medical care after you leave the hospital; such as family members, clergy, or others who provide services that are part of your care.

For Payment. We may use and disclose medical information about you for payment activities. For example, we may need to receive information about surgery you received at the hospital, so that we can submit payment to the provider. We may also receive information about a treatment that you are going to receive so that we can authorize prior approval or to determine whether we will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for operations. These uses and disclosures are necessary to run the managed care office and for us to make sure that all of our members receive quality care. For example, we may use medical information to review your treatment and services and to evaluate the performance of staff caring for you. We may also combine the medical information we have with medical information from other offices to compare how we are doing and to ascertain where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information, so that others may use it to study health care and health care delivery without learning who the specific patients are.

Treatment Alternatives. We may use and disclose medical information so that we can recommend possible treatment options, or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You do have the right to object to the sharing of this information.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who receive another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information. The process balances the research needs with the patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are.

As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Personal Representative. We may disclose your medical information to a personal representative who has authority to make health care decisions on your behalf.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as deemed necessary by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation. We may release medical information about you for workers compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risk. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may release medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information to a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, foreign heads of state, or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

- For the institution to provide you with health care;
- To protect your health and safety or the health and safety of others; or
- For the safety and security of the correctional institution.

Written Authorization. For any other use or disclosure of your medical information, SHPO will ask for your written permission before using or disclosing your information. You may cancel this permission at any time in writing, but SHPO cannot take back any uses or disclosures already made with your permission. There are many programs that have their own laws for the use and disclosure of information about you, which we too must follow. For example, you generally must give your written permission for SHPO to use and disclose your mental health and chemical dependency treatment records.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy, electronically or paper copies of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to SHPO to the below address. If you request a copy of the information, we may charge a fee for the costs of copying and mailing it to you.

We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by SHPO will review your request and the denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the second review.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for SHPO.

To request an amendment your request must be made in writing and submitted to SHPO to the below address. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by SHPO;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If we do deny your request, SHPO will send you a letter that tells you why your request is being denied and how you can appeal the denial. You will also receive information about how to file a complaint with SHPO.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. The accounting of disclosures will not include certain types of disclosures, such as for treatment, payment, or health care operations.

To request an accounting of disclosures, you must submit your request in writing to SHPO at the below address. Your request must state a time period, which may not be longer than six years from the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Samaritan Health Plans is legally obligated to notify any individual whose protected health information is affected by a security breach.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to SHPO to the below address. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work or by mail.

To request confidential communications you must make your request in writing to SHPO to the below address. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting SHPO by phone or mail – see the contact information below.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Samaritan Health Plan Operations by plan. Please refer to your Member Handbook or Evidence of Coverage for contact information. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

All complaints to SHPO must be submitted in writing to SHPO at the address below.

You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

If you have questions about this notice, or need this information in a different format, such as larger font, Braille, audiotape or in another language, please call:

Denise Severson
Samaritan Health Plans Compliance Officer

- 541-768-4550
- 1-800-832-4580
- TTY 1-800-735-2900

Or, write to:

Samaritan Health Plans
2300 NW Walnut Blvd
Corvallis, OR 97330

Samaritan Choice Plans
Samaritan Health Plans Operations
PO Box 336
Corvallis, Oregon 97339
choice.samhealthplans.org
Myhealthplan.samhealth.org