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, 2019. Previous documents that also explain your current benefits include: 2015 Samaritan Choice Medical and Pharmacy Member Handbook, 2015 Samaritan Choice Vision Member Handbook, and the Summary of Material Modifications (SMM) from 2015, 2016, 2017, and 2018.

KEEP THIS NOTICE WITH YOUR 2015, 2016, 2017, and 2018 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. You can request all plan documents by calling our Customer Service Department at 541-768-4550, toll-free 1-800-832-4580 (TTY: 1-800-735-2900), Monday through Friday, from 8 a.m. to 8 p.m. You can also visit our member website at choice.samhealthplans.org to view or download these documents.

Summary of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the benefits for the Samaritan Choice Wellness Plan. 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 (SBC) document.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
PREVENTIVE SERVICES		
Well baby care	$0, not subject to deductible	30%, not subject to deductible
Routine physicals	$0, not subject to deductible	30%, not subject to deductible
Routine gynecological exams	$0, not subject to deductible	30%, not subject to deductible
Immunizations	$0, not subject to deductible	30%, not subject to deductible
Colorectal screening	$0, not subject to deductible	30%, not subject to deductible
PROFESSIONAL SERVICES		
Primary care visits [1]	$25, after deductible	30%, after deductible
In-office procedures	$25, after deductible	30%, after deductible
Specialist visits	$40, after deductible	30%, after deductible
In-office procedures	$40, after deductible	30%, after deductible
Urgent care center visits	$40, after deductible	$40, after deductible
Surgery professional (at hospital or ASC)	$60, after deductible	30%, after deductible
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.		
Primary Care Home (PCH) Services	$0, not subject to deductible	Not covered
CARE COORDINATION SERVICES – For asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD).		
Office visit	$0, after deductible	30%, after deductible
EDUCATION SERVICES		
Office visit for specified education services	$0, after deductible	30%, after deductible
HEART HEALTH AND WELLBEING (HHWB) PROGRAM – In-Network WELLNESS PLAN 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.		
Cardiac rehabilitation services	$0, not subject to deductible	Not covered
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient room and board (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Inpatient rehabilitative care (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient rehabilitative care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Skilled Nursing Facility care	$0, after deductible	30%, after deductible
Bariatric surgery/gastric banding (Lap band) surgery [2]	$5,000, not subject to deductible (Does not apply to OOP limit)	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in-office procedures) (SHS designated facilities)	$150, after deductible	NA
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	$250, after deductible	30%, after deductible

Summary of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the benefits for the Samaritan Choice Wellness Plan. 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 (SBC) document.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
OUTPATIENT SERVICES (continued)		
Emergency department visits (unless admitted to hospital)	$150, after deductible	$150, after deductible
Radiology	$25, after deductible	30%, after deductible
Lab	$0, after deductible	30%, after deductible
VALUE-BASED SERVICES		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis) [3, 4]	$400, not subject to deductible (Does not apply to OOP limit)	30%, not subject to deductible (Does not apply to OOP limit)
High-tech imaging services [3, 4] (CT scans, MRIs and PET scans)	$200, not subject to deductible (Does not apply to OOP limit)	30%, not subject to deductible (Does not apply to OOP limit)
CHEMICAL DEPENDENCY		
Office visits	$40, after deductible	30%, after deductible
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Outpatient intensive services and programs (including partial hospitalization) for substance use	30%, after deductible	Not covered
Residential programs	30%, after deductible	30%, after deductible
MENTAL HEALTH		
Office visits	$25, after deductible	30%, after deductible
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Partial hospitalization	30%, after deductible	30%, after deductible
Residential programs	30%, after deductible	30%, after deductible
OTHER COVERED SERVICES		
Physical therapy	$35, after deductible	30%, after deductible
SHS Physical Therapy providers	$30, after deductible	NA
Occupational therapy	$35, after deductible	30%, after deductible
Speech therapy	$35, after deductible	30%, after deductible
Allergy injections (most) [5]	$15, after deductible	30%, after deductible
Injectables and other drugs administered in the office (other than oral medications) [5]	20%, after deductible	20%, after deductible
Ambulance, ground	30% after $100 copay, after deductible	30% after $100 copay, after deductible
Ambulance, air	30%, after deductible (Does not apply to OOP limit)	30%, after deductible (Does not apply to OOP limit)
Durable Medical Equipment (DME) & Prosthetics	30%, after deductible	50%, after deductible
Continuous glucose monitors [6]	10%, after deductible	50%, after deductible
Home health care	$30, after deductible	30%, after deductible
Hospice	$0, after deductible	30%, after deductible

Summary of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the benefits for the Samaritan Choice Wellness Plan. 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 (SBC) document.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
OTHER COVERED SERVICES (continued)		
Hearing aids	Covered up to $1,000/year, after deductible No limit for children ages 20 and under	Covered up to $1,000/year, after deductible No limit for children ages 20 and under
Acupuncture	$35, after deductible	35%, after deductible
Chiropractic [7]	$25, after deductible Covered up to $850/year	30%, after deductible Covered up to $850/year
Panniculectomy [8]	50%, not subject to deductible (Does not apply to OOP limit)	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/gastric lap banding is covered only at in-network/designated facilities and subject to its policies and surgical criteria.
[3] Value-based copay does not apply if coded as emergency room services. Cost shares will default to normal benefit for emergency room 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 Service at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900) to determine your copay or coinsurance levels and applicable services.
[6] Procedure codes that apply to the continuous glucose monitor benefit are as follows: A9276, A9277, A9278, K0553, and K0554.
[7] Chiropractic benefit only includes manipulations and exams. This benefit does not include x-rays, labs, 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 HSA Eligible High-Deductible Plan

The table below summarizes the benefits for the Samaritan Choice HSA Eligible High-Deductible Plan. 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 (SBC) document.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
PREVENTIVE SERVICES		
Well baby care	$0, not subject to deductible	30%, not subject to deductible
Routine physicals	$0, not subject to deductible	30%, not subject to deductible
Routine gynecological exams	$0, not subject to deductible	30%, not subject to deductible
Immunizations	$0, not subject to deductible	30%, not subject to deductible
Colorectal screening	$0, not subject to deductible	30%, not subject to deductible
PROFESSIONAL SERVICES		
Primary care visits [1]	$25, after deductible	30%, after deductible
In-office procedures	$25, after deductible	30%, after deductible
Specialist visits	$40, after deductible	30%, after deductible
In-office procedures	$40, after deductible	30%, after deductible
Urgent care center visits	$40, after deductible	$40, after deductible
Surgery professional (at hospital or ASC)	$60, after deductible	30%, after deductible
CARE COORDINATION SERVICES – For asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD).		
Office visit	$0, after deductible	30%, after deductible
EDUCATION SERVICES		
Office visit for specified education services	$0, after deductible	30%, after deductible

Summary of Benefits: Samaritan Choice HSA Eligible High-Deductible Plan

The table below summarizes the benefits for the Samaritan Choice HSA Eligible High-Deductible Plan. 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 (SBC) document.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient room and board (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Inpatient rehabilitative care (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient rehabilitative care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Skilled Nursing Facility care	$0, after deductible	30%, after deductible
Bariatric surgery/ gastric banding (Lap band) surgery [2]	$5,000, after deductible	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in-office procedures) (SHS designated facilities)	$150, after deductible	NA
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	$250, after deductible	30%, after deductible
Emergency department visits (unless admitted to hospital)	$150, after deductible	$150, after deductible
Radiology	$25, after deductible	30%, after deductible
Lab	$0, after deductible	30%, after deductible
VALUE-BASED SERVICES		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis)	$400, after deductible	30%, after deductible
High-tech imaging services (CT scans, MRIs and PET scans)	$400, after deductible	30%, after deductible
CHEMICAL DEPENDENCY		
Office visits	$40, after deductible	30%, after deductible
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Outpatient intensive services and programs (including partial hospitalization) for substance use	30%, after deductible	Not covered
Residential programs	30%, after deductible	30%, after deductible
MENTAL HEALTH		
Office visits	$40, after deductible	30%, after deductible
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, after deductible	NA
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, after deductible	30%, after deductible
Partial hospitalization	30%, after deductible	30%, after deductible
Residential programs	30%, after deductible	30%, after deductible

Summary of Benefits: Samaritan Choice HSA Eligible High-Deductible Plan

The table below summarizes the benefits for the Samaritan Choice HSA Eligible High-Deductible Plan. 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 (SBC) document.

Service	In-Network: Member Pays	Out-of-Network: Member Pays
OTHER COVERED SERVICES		
Physical therapy	$35, after deductible	30%, after deductible
SHS Physical Therapy providers	$30, after deductible	NA
Occupational therapy	$35, after deductible	30%, after deductible
Speech therapy	$35, after deductible	30%, after deductible
Allergy injections (most) [3]	$15, after deductible	30%, after deductible
Injectables and other drugs administered other than orally (when rendered in the office) [3]	20%, after deductible	20%, after deductible
Ambulance, ground	30% after $100 copay, after deductible	30% after $100 copay, after deductible
Ambulance, air	30%, after deductible	30%, after deductible
Durable Medical Equipment (DME) & Prosthetics	30%, after deductible	50%, after deductible
Continuous glucose monitors [4]	0%, after deductible	50%, after deductible
Home health care	$30, after deductible	30%, after deductible
Hospice	$0, after deductible	30%, after deductible
Hearing aids	Covered up to $1,000/year, after deductible No limit for children ages 20 and under	Covered up to $1,000/year, after deductible No limit for children ages 20 and under
Acupuncture	$35, after deductible	35%, after deductible
Chiropractic [5]	$25, after deductible Covered up to $850/year	30%, after deductible Covered up to $850/year
Panniculectomy	50%, after deductible	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/gastric lap banding is covered only at in-network/designated facilities and subject to its policies and surgical criteria.
[3] Contact Customer Services at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900) to determine your copay or coinsurance levels and applicable services.
[4] Procedure codes that apply to the continuous glucose monitor benefit are as follows: A9276, A9277, A9278, K0553, and K0554.
[5] Chiropractic benefit only includes manipulations and exams. This benefit does not include x-rays, labs, radiology, or other services that are not considered to be a manipulation treatment.

⬇ ⬇ ⬇ THIS SECTION REPLACES LANGUAGE IN THE PRESCRIPTION DRUG BENEFITS SECTION ON PAGES 12-13 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK ⬇ ⬇ ⬇

Summary of Benefits: Prescription Drug

Drug Tiers	Wellness Plan Pharmacy Benefits	HSA High-Deductible Plan Pharmacy Benefits
Tier 1- Preventive	$0	$0
Tier 2- Preferred Generic	$7 or 20% (whichever is greater)	$7 or 20% (whichever is greater), after deductible
Tier 3- Preferred Brand	$25 or 25% (whichever is greater)	$25 or 25% (whichever is greater), after deductible
Tier 4- Non-Preferred	50%	50%, after deductible
Tier 5- High-Cost Specialty	10%	10%, after deductible

Tier 1 – 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 Tier 1 insulin products, 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).

🡻🡻🡻 ANY REFERENCES TO THE SAMARITAN CHOICE HIGH-DEDUCTIBLE PLAN OPTION ON PAGES 4-12, 20 AND 25-26 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY HANDBOOK ARE NO LONGER APPLICABLE 🡻🡻🡻

For 2019, the Samaritan Choice High-Deductible Plan option will no longer be available. A new plan option, HSA Eligible High-Deductible, will be available.

🡻🡻🡻 THESE DEFINITIONS WERE ADDED IN THE DEFINITIONS SECTION ON PAGE 2 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻🡻🡻

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

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

Out-of-Network Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider. Also called "non-preferred provider", "nonparticipating provider" or "non-contracted provider".

🡻🡻🡻 THE LANGUAGE IN THESE DEFINITIONS REPLACES LANGUAGE TO THE CORRESPONDING TERM IN THE DEFINITIONS SECTION ON PAGE 2 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻🡻🡻

Copayment: A copayment or copay is a fixed amount (for example, $15) you pay for a covered health care service in place of or before the application of coinsurance. Members are responsible for copays and/or coinsurance at the time of service

after the deductible has been met, when a deductible applies. The amount can vary by the type of covered health care service.

Out-of-Pocket Limit: The most you pay during a benefit plan year (January 1 – December 31), before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance billed charges, or services your health insurance or plan doesn't cover. Some health insurance or plans do not count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses towards this limit. Also called "out-of-pocket maximum".

⬇ ⬇ ⬇ 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 document for further explanations of your benefits including limitations and exclusions.

Out-of-Pocket Limits

Samaritan Choice Wellness Plan	In-Network Medical & Pharmacy Out-of-Pocket Limit	Out-of-Network Medical & Pharmacy Out-of-Pocket Limit
Per member	$7,200	Unlimited
Per family	$14,400	Unlimited

Samaritan Choice HSA Eligible High-Deductible Plan	In-Network Medical & Pharmacy Out-of-Pocket Limit	Out-of-Network Medical & Pharmacy Out-of-Pocket Limit
Per member	$5,000	Unlimited
Per family	$10,000	Unlimited

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 listed in the table above, 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:

Samaritan Choice Wellness Plan:

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

Samaritan Choice HSA Eligible High-Deductible Plan:

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

Samaritan Choice Wellness Plan Out-of-Pocket Limit:

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

Samaritan Choice HSA Eligible High-Deductible Plan Out-of-Pocket Limit:

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

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 the chart below. No family will have to satisfy more than the annual family deductible each calendar year.

The following DO NOT count toward deductible:

Samaritan Choice Wellness Plan:

- SOME preventive services do not apply to your deductible obligation.
- Bariatric and gastric banding surgery/services
- Value-based procedures/services
- Panniculectomies
- Other services outlined in this document

Samaritan Choice HSA Eligible High-Deductible Plan:

- SOME preventive services do not apply to your deductible obligation.

Plan	Maximum Lifetime Benefit	Annual Individual Deductible	Annual Family Deductible
Wellness Plan option	None	$350 (Medical only)	$1,050 (Medical only)
HSA Eligible High-Deductible Plan option	None	$2,700 (Integrated Medical & Pharmacy deductible)	$5,400 (Integrated Medical & Pharmacy deductible)
Amounts assessed for in-network and out-of-network services apply towards the same deductible, if a deductible applies.			

🡻 🡻 🡻 THE LANGUAGE IN THIS BENEFIT REPLACES LANGUAGE IN THE SERVICE AREA AND OUT-OF-AREA SERVICES SECTION ON PAGES 13-14 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

Service Area and Out-of-Area Services

The Samaritan Choice Plans service area is defined as Linn, Benton, Lincoln, and Tillamook Counties. Services done within the country, out of our service area, will be paid based on whether the billing provider is contracted with Samaritan Choice Plans. All plan benefit limits and prior authorization requirements apply.

Out-of-the-Country Coverage

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

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

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

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

PLEASE NOTE:

Not all providers in our service area are considered in-network providers. Not all providers outside our service area are considered out-of-network providers. Please call Customer Service to verify the network status of your provider before obtaining services: 541-768-4550, toll-free 1-800-832-4580 (TTY: 1-800-735-2900).

🡻 🡻 🡻 THESE PLAN BENEFIT DESCRIPTIONS REPLACE LANGUAGE TO THE CORRESPONDING BENEFITS IN THE PLAN BENEFITS SECTION ON PAGES 23-25, 27, 29, AND PAGE 32 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

Ambulance- Services of a state-certified ambulance are covered. Air transportation is also covered, but only to the nearest hospital capable of treatment, when ground transportation is inappropriate, and when medically necessary. The allowable for any medically appropriate air ambulance service received from an out-of-network provider will be reimbursed at up to 250% of the Medicare allowable. Please be aware that services provided by any out-of-network provider are likely to be costlier than

those you would receive from a network provider, and your cost share may be higher. The out-of-network provider may also choose to balance bill you for any amount not paid by this Plan. For the Wellness Plan, cost shares for air ambulance services do not apply to the out-of-pocket limit.

Chiropractic- Services are covered up to $850 a year for manipulations and exams. Manipulations are covered; x-rays and labs are not covered under this benefit.

Diabetic Supplies- Diabetic supplies are covered. The following diabetic supplies are covered with a $0 copay: gauzes, syringes, needles, lancets, betadine swabs, tape, alcohol and alcohol swabs, diabetic shoes and inserts and the fitting. Some items may be purchased at a pharmacy.

Durable Medical Equipment (DME) and Prosthetics- The purchase or rental of durable medical equipment (including crutches, wheelchairs, orthopedic braces, glucometers, and equipment for administering oxygen) and prosthetics are covered. Durable medical equipment must be prescribed in writing by a licensed MD, DO, DDS, DMD, or DPM. If the billed amount is greater than $1,000 for purchase, or the rental fee is greater than $1,000 per month or the rental length is greater than 3 months, Samaritan Choice Plans must prior authorize the expense. Please refer to the Benefits Exclusion section for more information on items not covered.

- Bras following a mastectomy are covered under Samaritan Choice Plans DME benefit. No authorization is needed and there is no limit to the number of bras allowed per year. Swimwear is not covered for any reason under the Plan.
- Breast Prosthesis, either internal or external, as a result of a mastectomy, regardless where the original service took place, is covered. Removal or replacement of breast prosthesis is covered only according to certain criteria. Please contact Samaritan Choice Plans at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900) for more information. The Women's Health and Cancer Rights Act (WHCRA) requires that Samaritan Choice Plans cover services that support rehabilitation and reconstruction services in the instance that a member receives these services due to cancer and related treatment.
- Breast Pumps and Supplies are covered under the preventive benefit. If purchased at an out-of-network provider, this benefit will be considered out-of-network and a higher coinsurance will apply.
- Diabetic Equipment is covered, generally classified as durable medical equipment, with a 30% coinsurance when in-network, unless otherwise stated. The following diabetic equipment is covered with a $0 copay: diabetic pumps, glucose monitors, and test strips. Continuous glucose monitors require prior authorization when the billed amount is greater than $1,000 for purchase, or the rental fee is greater than $1,000 per month or the rental length is greater than 3 months. Continuous glucose monitors will have a 10% coinsurance when in-network for the Wellness Plan option and a 0% coinsurance when in-network for the HSA Eligible High-Deductible Plan option. Diabetic supplies are considered a separate benefit from diabetic equipment. See the Diabetic Supplies benefit description of this document for more information.
- Maxillofacial Prosthetic Services, to restore and manage head and facial structures that cannot be replaced with living tissue, are covered. The treatment must be necessary to control or eliminate infection or pain. Treatment is only covered when the damage results from disease, trauma, or birth and developmental deformities. Cosmetic procedures are not covered.
- Medical Foods, non-prescription and prescription elemental enteral formula and parenteral formulas, ordered by a physician for home use, to treat severe intestinal mal-absorption and/or when it is the only source of nutrition, is covered at the DME benefit level; this may require prior authorization. If non-prescription elemental enteral formula is ordered by a physician, the physician must write a prescription for the item and the member will need to submit a Member Reimbursement form.
- Orthotics, medically necessary custom made or fitted foot orthotics, are covered. A licensed physician or podiatrist must prescribe the device. There is a $500 lifetime limit for members 18 years and older; members ages 17 and under do not have a lifetime limit.

- Vision Hardware after cataract surgery, or due to medical needs, is covered under the DME benefit. Hardware needed after cataract surgery is a one-time per eye benefit.

Emergency Services- Medically necessary emergency care. See the Definitions section for information about true emergencies. When feasible, emergency care should be obtained at a SHS facility.

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

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

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

- Preventive Colorectal Screenings- We cover services for colorectal cancer screening for any individual at high risk and as a part of an individual's routine preventive care.

  For the purposes of this Plan, members that are at high risk for colorectal cancer are:
  - Individuals who have a family history of colorectal cancer; or
  - A prior occurrence of cancer or precursor neoplastic polyps, or a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease, or ulcerative colitis.
- Preventive Gynecological Exams- These services are covered.
- Preventive Immunizations- We cover immunizations recommended by the Center of Disease Control and Prevention, as medically appropriate. Human papilloma virus (HPV) vaccine is covered as medically appropriate as determined by the members' physician. Covered expenses do not include immunizations for the sole purpose of travel, school, work/ occupation, or residence in a foreign country. See the Benefit Exclusions section.
- Preventive Prostate Screening- Screening exams, each calendar year for men age 50 and over, are covered.
- Preventive Routine Physical Exams- Routine physical exams can include related lab and radiology services, and bone density screening for patients considered at risk per Medicare guidelines.
- Preventive Screening Mammograms- Screening mammograms are covered.
- Preventive Well-Baby Care- Well-baby care is covered.
- Preventive Women's Care Services- Women's care services are covered.

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

Value-based services- The copays or coinsurance for these value-based procedures and services are in addition to a member's Wellness Plan or HSA Eligible High-Deductible Plan deductible, regular copayment, or coinsurance as applicable.

The value-based radiology tier is a cost group that requires plan members to pay a copay for each of the following diagnostic tests and imaging services:

- MRIs
- CT scans
- PET scans

The value-based procedures tier is a cost group that requires plan members to pay a copay for each of the following procedures:

- Spine surgery for pain
- Arthroscopies
- Shoulder surgery for Osteoarthritis

Wellness Plan Only: The value-based copays do not count toward the member's yearly out-of-pocket limit. Value-based service cost amounts WILL apply to the members' out-of-pocket limit when billed with a cancer diagnosis.

NOTE: Please review the Summary of Benefits section of this document for copay information. Copays may be different based on the Plan you are enrolled in.

Services described (MRI, CT scans, back and/or neck surgeries, inpatient hospital stays and PET scans) and potentially related services may require prior authorization. Please review the Prior Authorization section.

🡻 🡻 🡻 THIS LANGUAGE REPLACES LANGUAGE IN THE DRUGS AND MEDICATIONS PORTION OF THE BENEFIT EXCLUSIONS SECTION ON PAGES 32-33 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

This Plan does not cover the following drugs and medications:

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

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

2019 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 in-network and out-of-network 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:

- Bariatric surgery (benefit is for in-network/designated facilities only)
- Capsule/wireless endoscopies and motility monitoring studies
- Durable Medical Equipment (DME) and supplies, prosthetics, and orthotics with billed amount greater than $1,000 for purchase. Rental items with rental fee greater than $1,000 per month or rental length greater than 3 months
- Elective termination of pregnancy
- Genetic testing
  - Exception: standard prenatal testing
- Hospitalization for dental procedures including Ambulatory Surgical Center (ASC)
- Hyperbaric oxygen therapy
- Infused/injected medications (see attached list)
- Inpatient hospital care (including mental health and substance use disorder) *
  - Exception: labor & delivery
  - Exception: newborn stays less than 5 days
- Inpatient rehabilitation care*
- Neck and back surgery (including those done as in-office procedures)
- Panniculectomy
- Potentially cosmetic, experimental or reconstructive surgery and services, including new and emerging technologies and clinical trials**
- Radiological services (for the following):
  - Magnetic Resonance Imaging (MRI)
  - Positron Emission Tomography (PET) scans
  - Virtual colonoscopy
- Residential services for mental health and substance use disorder
- Sclerotherapy
- Skilled Nursing Facility (SNF)
- Skin substitute- tissue engineered
- Transplants
  - Exception: corneal transplants
- Urine drug tests (prior authorization required after 12 units per year)
- Uvulopalatopharyngoplasty

* 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.

** Cosmetic, experimental or reconstructive surgery and services, including new and emerging technologies and clinical trials, have the following requirements and considerations:

- Cosmetic and experimental services, which may include new or emerging technologies, often do not meet medical necessity and are generally not covered.
- Services which may be considered reconstructive will require prior authorization to demonstrate medical necessity regardless of dollar amounts or codes billed.
- Prior authorization for new or emerging technologies is required to ensure that the service meets current accepted standards of care.

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 that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

Prior authorization by Samaritan Choice Plans is required for the following drugs when paid under the medical plan. Any other brand name equivalents of the medications below also require prior authorization:

- Abatacept (Orencia)
- Abobotulinumtoxin A (Dysport)
- Adalimumab (Humira)
- Aflibercept (Eylea)
- Agalsidase Beta (Fabrazyme)
- Albiglutide (Tanzeum)
- Alemtuzumab (Campath, Lemtrada)
- Alglucosidase Alfa (Myozyme)
- Alpha-1 Proteinase Inhibitor (Aralast NP, Glassia, Prolastin-C, Zemaria)
- Antihemophilic Factor (Hemofil M, Koate, Monoclate-P)
- Belatacept (Nulojix)
- Belimumab (Benlysta)
- Bevacizumab (Avastin)
- Bortezomib (Velcade)
- C1 Esterase Inhibitor (Berinert, Cinryze, Haegarda, Ruconest)
- Certolizumab (Cimzia)
- Cetuximab (Erbitux)
- Coagulation Factor IX (Idelvion)
- Coagulation Factor VIIa (NovoSeven RT)
- Collagenase, Injectable (Xiaflex)
- Daratumumab (Darzalex)
- Denosumab (Prolia, Xgeva)
- Eculizumab (Soliris)
- Edetate (EDTA) Chelation
- Elotuzumab (Empliciti)
- Epoetin and Darbepoetin (Epogen, Procrit, Aranesp)
- Epoprostenol (Flolan, Veletri)
- Etanercept (Enbrel)
- Fulvestrant (Faslodex)
- Glatiramer Acetate (Copaxone, Glatopa)
- Golimumab (Simponi, Simponi
- Aria)
- Granulocyte Colony-Stimulating Factor (G-CSF) (filgrastim, Granix, Neupogen, Zarxio)
- Granulocyte-Macrophage Colony-Stimulating Factor (GM-CSF) (sargramostim, Leukine)
- Hyaluronic Acid, Intra-articular Injection (Durolane, Gel-One)
- Icatibant (Firazyr)
- Idursulfase (Elaprase)
- Imiglucerase
- Immune Globulin Intravenous (IVIG, Bivigam, Carimune, Cuvitru, Gammagard, Octagam, Privigen)
- Infliximab (Remicade, Inflectra, Renflexis)
- Interferon and Peginterferon (Intron A, Avonex, Betaseron, Extavia, Rebif, Pegasys)
- Ipilimumab (Yervoy)
- Lanreotide (Somatuline)
- Laronidase (Aldurazyme)
- Mecasermin (Increlex)
- Mepolizumab (Nucala)
- Natalizumab (Tysabri)
- Nivolumab (Opdivo)
- Octreotide (Sandostatin)
- Ocrelizumab (Ocrevus)
- Omalizumab (Xolair)
- OnabotulinumtoxinA (Botox)
- Oprelvekin (Neumega)
- Palifermin (Kepivance)
- Palivizumab (Synagis)
- Palonosetron (Aloxi)
- Panitumumab (Vectibix)
- Pasireotide (Signifor)
- Pegaptanib (Macugen)
- Pegloticase (Krystexxa)
- Pegvisomant (Somavert)
- Pembrolizumab (Keytruda)
- Pertuzumab (Perjeta)
- Ranibizumab (Lucentis)
- RimabotulinumtoxinB (Myobloc)
- Rituximab (Rituxan)
- Romiplostim (Nplate)
- Secukinumab (Cosentyx)
- Somatropin (Genotropin, Humatrope, Norditropin, Saizen, Omnitrope, Nutropin)
- Taliglucerase (Elelyso)
- Teduglutide (Gattex)
- Teriparatide (Forteo)
- Tocilizumab (Actemra)
- Trastuzumab (Herceptin)
- Ustekinumab (Stelara)
- Vedolizumab (Entyvio)
- Velaglucerase (Vpriv)

⬇ ⬇ ⬇ 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 written grievance and/or appeal in writing with Samaritan Choice Plans (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 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, toll-free 1-800-532-4580 (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 acknowledgement 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 acknowledgement 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.

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

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

External Review

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

- 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 5 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, OR 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 1-800-832-4580 (TTY: 1-800-735-2900).

Expedited Appeals

Urgent is determined when the member's health or life would be in 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 external expedited review, send your written request along with a completed Authorization to Release Health Plan Records for External Review form to:

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

Call our Customer Service Department:

541-768-4550, toll-free 1-800-832-4580 (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 1-800-832-4580 (TTY: 1-800-735-2900), or online at choice.samhealthplans.org:

- Authorized Representative
- Appeal Request

Your Appeal Rights

You have the right to:

- File a grievance about and appeal any decision we make regarding availability, delivery, or quality of health care services, including 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 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, contact our Samaritan Health Plans Customer Service Department:

By phone:

541-768-4550, toll-free 1-800-832-4580 (TTY: 1-800-735-2900)

In writing:

Samaritan Choice Plans- Appeals Team
P.O. Box 1310
Corvallis, OR 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
P.O. 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.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon treatment goals, to the degree possible.

🡻🡻🡻 THIS LANGUAGE REPLACES LANGUAGE IN THE PLAN DISCLOSURES SECTION ON PAGES 42-50 IN 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 document. You may access your plan documents 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 or more employees) that provides a group health plan must continue to offer an employee the same coverage, under the same terms as if they had continued to work, while on 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 3 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 and Addiction Equity Act (MHPAEA) of 2008

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

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

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP

programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual coverage through the Health Insurance Marketplace. For more information, visit 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, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

GINA expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under GINA, group health plans cannot base premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans from requesting or requiring an

individual to undergo genetic tests and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

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

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.

Women's Health and Cancer Rights Act (WHCRA)

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

The required coverage includes:

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

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. 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 following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26 (Section 2714, Patient Protection and Affordable Care Act of 2010 (PPACA))

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll with 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 at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900).

Lifetime Limit No Longer Applies 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 receiving the notice to request enrollment. For more information contact Samaritan Choice Plans at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900).

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 at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900).

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 at 541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900).

*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 Samaritan Choice Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive information about your plan and benefits

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

Continue group health plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that 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 be provided upon request.

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

Provision of certificate upon request

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

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

Specification of benefits

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

Nondiscrimination Notice

Samaritan Health Plans 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 Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Samaritan Health Plans:

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, toll-free 1-800-832-4580 (TTY: 1-800-735-2900).

If you believe that Samaritan Health Plans 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, toll-free 1-800-832-4580 (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.

Important Notice from Samaritan Health Services About Your Prescription Drug Coverage

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Samaritan Health Services has determined that the prescription drug coverage offered by Samaritan Choice Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare, and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Samaritan Choice Plans coverage may be affected. Samaritan Choice Plans prescription drug coverage includes the Preventive Tier with $0 copay; the Preferred Generic Tier with $7 copay or 20% coinsurance (whichever is greater); the Preferred Brand Tier with $25 copay or 25% coinsurance (whichever is greater); the non-Preferred Brand Tier with 50% coinsurance; and the High-Cost Specialty Tier with 10% coinsurance. In addition to prescription drugs, your current coverage pays for other health expenses. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month, for every month that you did not have coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher

than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty), as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Please call Samaritan Choice Plans at 541-768-4550. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Samaritan Choice Plans changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

For more information about Medicare prescription drug coverage:

- Visit Medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at Socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

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

Date of Original Notice:	January 1, 2008
Name of Entity:	Samaritan Health Services
Contact Office:	Samaritan Choice Plans
Address:	2300 NW Walnut Boulevard Corvallis, OR 97330
Phone Number:	541-768-4550 or toll-free 1-800-832-4580 (TTY: 1-800-735-2900)

Samaritan Choice Plans
Samaritan Health Plans
PO BOX 336
Corvallis, OR 97339
choice.samhealthplans.org
Myhealthplan.samhealth.org