Samaritan Health Plans

Group Vision Insurance

Samaritan Health Plans, Inc.
2300 NW Walnut Blvd
Corvallis, Oregon

Kelley Kaiser, MPH
Chief Executive Officer

DRAFTER'S NOTE: Employer name and Effective date of coverage will populate based on group name and effective date. Plan name will populate based on group's selection. Group's Group Number will be populated based on number assigned in SHP system. Month and Year will populate with effective Month and Year of Group. Policyholder Name will be populated based on information from the group application.

Employer name: [Name of Employer]

Effective date of coverage: [Effective date]

Plan: Group Vision Plan

Group Number: [assigned group number]

THIS AGREEMENT made and entered into this 1st day of [Month & Year] and between Samaritan Health Plans, Inc., an Oregon not-for-profit corporation, and [Policyholder Name] (herein called "Policyholder").

In consideration of the Policyholder's payment of monthly premium in the amounts and at the time required, Samaritan Health Plans will insure each enrolled person in accordance with the provisions and subject to the conditions of this Group Policy.

This document and any endorsements, riders, amendments, applications or attached papers, if any, describes the benefit coverage for Vision benefits for eligible participants issued by Samaritan Health Plans to the Policyholder. The Group Policy becomes effective at 12:01 a.m. on the date written above, and continues in effect for a period of 12 months, provided premiums are paid when due and in the required amounts. The Group Policy is automatically renewed from month to month thereafter unless modified or terminated.

Every effort has been made to make these explanations as accurate as possible in accordance with the Life and Health Insurance Policy Language Simplification Act, the Affordable Care Act (ACA) and any applicable Oregon Revised Statutes.

For more information, contact Samaritan Health Plans at:

Samaritan Health Plans
2300 NW Walnut Blvd.
Corvallis, OR 97330

Member Services
Monday through Friday 8 a.m. to 8 p.m.
541-768-4550 / 1-800-832-4580
TTY 1-800-735-2900

samhealthplans.org

To Our Members

Dear Samaritan Health Plans Member:

We welcome you to your Samaritan Health Plans Vision Plan. We are proud to serve our neighbors of Oregon and contribute to the health and well-being of our communities!

Please read this document and your Benefit Schedule carefully. It provides you with the details regarding your benefits and any limitations.

You also have 24/7 access to this document and all member forms online at samhealthplans.org.

For questions about your vision benefits, our Member Services Department is available to assist you, **Monday through Friday:**

- **By phone**
  8 a.m. to 8 p.m. at 541-768-4550 or toll free at 1-800-832-4580 (TTY 1-800-735-2900)
- **By email**
  8 a.m. to 5 p.m., at MemberServices@samhealth.org
- **In person**
  8:30 a.m. to 5 p.m., at 2300 NW Walnut Boulevard, Corvallis Oregon 97330

We will mail you an ID card, separate from this document. If you need health care services before you receive your ID card, please contact our Member Services Department for assistance.

We look forward to serving you!

Sincerely,

Kelley Kaiser, Chief Executive Officer
Samaritan Health Plans

Stronger, healthier, together.

Discrimination Is Against the Law

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, 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
P.O. Box 1310 Corvallis OR 97339
541-768-4550, TTY: 1-800-735-2900, Fax: 541-768-9791
dseverson@samhealth.org

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

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Translation Assistance

Arabic - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-832-4580 (رقم هاتف الصم والبكم: 1-800-735-2900)

Cambodian/Mon-Khmer ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-832-4580 (TTY: 1-800-735-2900)។

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-832-4580 (TTY: 1-800-735-2900)

Farsi/Persian - توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-832-4580 **(TTY:** 1-800-735-2900**)** تماس بگیرید.

Filipino - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-832-4580 (TTY: 1-800-735-2900).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-4580 (ATS : 1-800-735-2900).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-4580 (TTY: 1-800-735-2900).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-832-4580 (TTY: 1-800-735-2900).

Indonesian - PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-800-832-4580 (TTY: 1-800-735-2900).

Japanese - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-832-4580 (TTY: 1-800-735-2900) まで、お電話にてご連絡ください。

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-832-4580 (TTY: 1-800-735-2900) 번으로 전화해 주십시오.

Lao - B Åŷ ̧ǿ : ÆḤ ̧ ̔ Ḥ æḤǾĭ ̏Ọ Ẃ ̧ ̄ ̧ ỳ ̧ ̔ **,** Ụ ̧ ǾøŊ Ụ ̧ Øŷ Ħſ ĭ₤Ɓ Å Ị ǾẂ ̧ ̄ ̧ **,** BÅſ øŃ ̄ ⅞ Ŵ Ḥ**,** A ẄǾ ẄẂe ẄΔ₤ łæḤǾ**.** Bǽ Ỳ 1-800-832-4580 **(TTY:** 1-800-735-2900**).**

Oromo/Cushite - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-832-4580 **(TTY** 1-800-735-2900**).**

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-832-4580 (TTY: 1-800-735-2900).

Romanian - ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-832-4580 **(TTY:** 1-800-735-2900

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-4580 (TTY: 1-800-735-2900).

Serbo-Croation - OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-832-4580 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2900).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-4580 (TTY: 1-800-735-2900).

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-832-4580 (TTY: 1-800-735-2900).

Turkish - DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-800-832-4580 (TTY: 1-800-735-2900) irtibat numaralarını arayın.

Ukranian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-832-4580 **(телетайп:** 1-800-735-2900**).**

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-832-4580 (TTY: 1-800-735-2900).

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Definitions

Adverse Benefit Determination – The claims administrator's denial, reduction or termination of a health care item or service, or the failure or refusal of the claims administrator to provide or to make a payment in whole or in part for a health care item or service, that is based on a:

- Denial of eligibility for or termination of enrollment in the plan;
- Rescission or cancellation of a policy or certificate;
- Imposition of a preexisting condition exclusion, source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or
- Determination that a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care.

Allowed amount – This is the maximum amount that is payable to the provider of service for medically necessary, covered services. This amount is the combination of the Samaritan Health Plans payment and any deductible, coinsurance, or copayment owed by the member. Amounts allocated to deductible, coinsurance, or copayments are so indicated by the Explanation of Benefits. In-network providers must write off, or not charge, the Samaritan Health Plans patient for balances other than the deductible, coinsurance, or copayment. Providers can collect from members for services that are not covered benefits under the Samaritan Health Plans policy.

Authorized Representative – An individual who by law or by the consent of a person can act on behalf of the person. The authorization must be made by the completion of an Appointment of Authorized Representative Form that is available from Member Services.

Authorized Services – Means services or supplies that have been approved by the claims administrator.

Balance billing – Means when a provider bills you for the balance remaining on the bill that the plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $10, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider. You cannot be balance billed if you receive covered services by an in-network provider.

Benefit year – The benefit year for coverage under this Group Certificate begins on the Effective Date of coverage set forth in the front of this Group Certificate, and on each anniversary of that Effective Date.

Calendar year – The 12-month period starting on each January 1st and ending on the next December 31st of the same year.

Claim – A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider in accordance with the terms of the plan for items or services you think are covered.

Claims administrator – Samaritan Health Plans serves as the claims administrator with respect to claims made under this plan.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA is a Federal law that provides rights to temporary continuation of group health plan coverage for certain employees, retirees and family members at group rates when coverage is lost due to certain qualifying events.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance of 20% would be $20. The plan pays the rest of the allowed amount).

Coordination of benefits – A method for determining the amount that each plan should pay, when a covered person is covered under two or more health care plans. It determines which plan is primary, and which plan is secondary, thus "coordinating" benefits between the two plans.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health service. A copayment, or copay, is a flat fee in place of or before the application of coinsurance. Copayments and/or Coinsurance are not applied toward the deductible. Members are responsible for payment of copays at the time of service.

Covered services – A service or supply that is specifically described as a benefit of this plan.

DRAFTER'S NOTE: Accumulator credit will be negotiated and determined by group size and when requested by the employer.

Deductible – The portion of the cost of covered services a member is obligated to pay before the plan will provide payment for benefits. Both the deductible and out-of-pocket maximum are accumulated on a calendar year basis. For mid-year carrier coverage changes, [deductible credit][deductible credit and co-insurance credit] will be transferred over when Samaritan Health Plans has received all pertinent information.

Dependent – Any individual who is or may become eligible for coverage under the terms of the plan because of a relationship to a covered employee.

Eligibility – The requirements that you must meet in order to qualify for and remain enrolled in the plan. See "Eligibility and Enrollment for more information.

Eligible employee – Means an employee of the employer that has satisfied the eligibility requirements established by the employer. The eligibility requirements must in all cases meet the following standards:

DRAFTERS NOTE: Work hours requirement will be populated based on the group's required work hours.

- The work hours requirement can range from [15< 17.5] to 40 hours per week; and
- A waiting period requirement cannot exceed 90 days.

An eligible employee does not include an employee who works on a temporary, seasonal, or substitute basis.

Employer – The employer that has entered into this Group Policy with Samaritan Health Plans for the benefit of its eligible employees and their dependents (which is the "sponsoring employer"). Where the context so implies, an "employer" also includes a member of a controlled group of companies within the meaning of IRC § 414(b), (c) or (m) that includes the sponsoring employer, and which the sponsoring employer has extended participation in the plan.

Grievance – Means either of the following:

A communication from a member or authorized representative of a member expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

- In writing, for internal appeal or an external review
- In writing or orally, for an expedited response or an expedited external review

A written complaint submitted by a member or authorized representative regarding the:

- Availability, delivery or quality of health care service
- Claims payment, handling or reimbursement for health care services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination
- Matters pertaining to the contractual relationship between a member, employer, and Samaritan Health Plans

Group Certificate – This certificate, which sets forth the terms and conditions of the benefits that Samaritan Health Plans has contracted to provide to eligible members. The Group Certificate serves as the services provided by Samaritan Health Plans and responsibilities between Samaritan Health Plans and the employer, and when benefit coverage is distributed to a member, as the "Member Certificate."

Group Policy – This Group Certificate, the Group's Contract Application (which is incorporated herein by reference), and any amendments, exhibits, supplements, addenda, attachments, endorsements, applications, health statements or riders, and any information incorporated or submitted as part of the Application for this Group Policy.

In-network – The covered services or supplies that you receive from an in-network provider who has a contract with Samaritan Health Plans and who has agreed to provide services to members of a plan. You generally will have a reduced out-of-pocket expense if you see a provider in the network.

In-network coinsurance – The percent (for example, 30%) you pay of the allowed amount for covered services provided by an in-network provider. In-network coinsurance usually is less than out-of-network coinsurance. See your Benefit Schedule.

In-network copayment – A fixed amount (for example, $35) you pay for covered services provided by an in-network provider. In-network copayments usually are less than out-of-network copayments. See your Benefit Schedule.

Incur – The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the covered person receives it.

Medically necessary – 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, are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate or medically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease;
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease
- In Samaritan Health Plan's determination as based on available information and documentation, and in accordance with the terms of the plan; and
- The least costly of the alternative supplies or levels of service which can be safely provided to the patient. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the patient's home, without harm to the patient

Services and supplies intended to diagnose or screen for a medical condition are not considered medically necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing. Medically necessary care does not include custodial care.

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

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

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

Member – An eligible employee, dependent of the eligible employee or an individual otherwise eligible for coverage and who has enrolled for coverage under the terms of this plan and under procedures established by your employer. A member may sometimes be referred to as an "enrollee."

Open enrollment period – The time each year during which eligible employees may change elections regarding coverage and add eligible dependents who may not have been previously enrolled.

Out-of-network coinsurance – The percent (for example, 70%) you pay of the allowed amount for covered services to providers who are not in-network providers. Out-of-network coinsurance may be more than in-network coinsurance.

Out-of-network copayment – A fixed amount (for example, $40) you pay for covered services from providers who do not contract with your health insurance or Plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network providers – Providers that have not contracted with the Samaritan Health Plans to provide benefits to persons covered under this plan (sometimes referred to as non-participating

providers). Out-of-network providers will be reimbursed at the allowed amount for the service provided.

Participant – An employee, or a former employee (such as an employee receiving COBRA continuation coverage) who is enrolled in the plan.

Plan – This plan of benefits established and maintained by the employer, the benefits of which are provided under the Group Policy.

Qualified domestic partner – Means either a "statutory domestic partner" or a "non-statutory domestic partner."

- A "statutory domestic partner" is a person of the same sex as the employee who, with the employee, has been issued a Certificate of Registered Domestic Partnership described in ORS 106.320 or who has otherwise entered into a legally-recognized civil contract in regard to such domestic partnership.
- A "non-statutory domestic partner" is a person of either the same sex or opposite sex as the employee who is not a statutory domestic partner, but who lives with an employee in a long-term, committed relationship. The employer may, but is not required to, offer coverage under the plan to non-statutory domestic partners. In addition, it may offer coverage to same sex domestic partners without offering coverage to opposite sex domestic partners, or vice versa.

Your employer, and not Samaritan, will establish the conditions and procedures for determining whether a person qualifies as a domestic partner who is eligible for coverage.

Services – Health care diagnosis, treatments, procedures, equipment, medications, or devices. Services include supplies to support a service.

Service area – Samaritan Health Plan options are available for purchase statewide in the State of Oregon for Oregon domiciled businesses.

Spouse – To whom you are married.

Supplies – Consumable goods to support health care services.

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

Waiting period – The period of employment or membership with the employer or a group that an eligible employee must complete before becoming eligible for coverage under the plan, as established by the employer. The waiting period may not exceed 90 days.

We, us, or our – Refers to Samaritan Health Plans, Inc. ("Samaritan Health Plans").

You or your – The person enrolled for coverage in the plan. Where the context so implies, it also includes any of your enrolled dependents.

Service Area and Provider Network

Samaritan Health Plans plan options are available for purchase within the State of Oregon for Oregon domiciled businesses.

Please call Samaritan Health Plans for details on your provider network.

Samaritan Health Plans contracts directly with providers throughout the State of Oregon. In addition, Samarian Health Plans uses the First Choice Health Network to supplement its provider panel in Oregon. The First Choice Health Network also extends to 7 other states in the Northwest. For contracted provider coverage in the remainder of the United States, Samaritan Health Plans uses the First Health Network.

Not all providers in our service area are considered to be an in-network provider. Please call our Member Services Department or visit www.samhealthplans.org **to verify the network status of your provider before getting services. Contact us at 541-768-4550; toll free1-800-832-4580 or TTY 1-800-735-2900.**

Coverage Outside of the United States

We cover all **urgent** and **emergent** services received outside of the country at the in-network provider benefit level. Any other services besides urgent and emergent services provided out of the country will not be covered.

Members may need to pay for services out-of-pocket at the time of service. Please fill out, and submit a Member Reimbursement Form, and provide all receipts and pertinent documentation of the covered health care expenditures to the Plan for evaluation and reimbursement. All member reimbursement requests must be submitted to Samaritan Health Plans within 365 days of the date services were obtained.

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

- Member name
- Member ID number
- Services rendered
- Date of service
- Provider name
- Charged amount by service received
- Where you received services
- Diagnosis
- Procedure code
- 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 Health Plans will convert currency as of the date of processing.

PLEASE NOTE:

Not all providers or pharmacies in our service area are considered to be an in-network provider. Not all providers or pharmacies outside our service area are considered to be an out-of-network provider.
Please call Member Services to verify the network status of your provider or pharmacy before obtaining services at: 541-768-4550 or 800-832-4580.

Becoming a Samaritan Member

When you become a member of Samaritan Health Plans, you will receive new member materials regarding your vision care benefits from your employer. The following information and materials are found in your new member materials. The materials include a summary of your benefits and coverage, and important information about your appeal rights. You may, at any time, request a copy of these materials. If requested, we will send you a copy of the requested materials within 30 days of your request.

Please keep these materials for future reference:

- Welcome letter
- Vision Certificate (this document)
- Vision Benefit Schedule

If you are missing any of these materials, please call our Member Services Department or visit www.samhealthplans.org to verify the network status of your provider before getting services. Contact us at 541-768-4550; toll free1-800-832-4580 or TTY 1-800-735-2900.

Your Health Plan Member Identification (ID) Card

You and your enrolled dependents will each receive a member identification (ID) card once you have been enrolled. You must present this card when you receive services. It lists information about you, needed at your appointment for your physician's office to bill for services correctly. If you have misplaced your ID card, changed personal information or added new members, please call us and we will send you a new card.

Provider Directory

You can find information on participating providers:

- On the Samaritan Health Plans website. Go to samhealthplans.org/groupbenefits
- On the Member Portal at MyHealthPlan.samhealth.org
- By contacting our Member Services department, who can tell you if a provider is participating or not. You can also request a copy of the provider directory, which we will provide at no cost to you.

Interpreter Services

If you need a foreign language interpreter at your appointment, please contact Samaritan Health Plan's Member Services Department to make those arrangements. To make sure that an interpreter will be at your appointment, please have this information ready when you call:

- The name of the person or persons the appointment is for
- The member's ID number
- A home phone number

- The date and the time of the appointment
- The name of the health care provider
- The full address of the provider's office
- The phone number of the provider's office
- The reason for the appointment

Please call the Samaritan Health Plans Member Services Department at 541-768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900 with all of the necessary information at least 72 hours before your appointment.

Member Portal

Your member portal at MyHealthPlan.samhealth.org provides you with secure, 24/7 access to:

- Provider directories
- Claims processed by your health plan
- Details about your eligibility with the plan, including the amount you have met toward your deductibles and your coverage limits.
- For questions about your member portal and technical support if needed, please call the Member Services Department at 541-768-4550, toll-free 1-800-832-4580 (For Hearing Impaired, call 1-800-735-2900), Mon.–Fri., 8 a.m. to 8 p.m. The Member Services Department can also be reached via email at MemberServices@samhealth.org.

Eligibility and Enrollment

Employees

Your employer decides the minimum number of hours employees must regularly work each week in order to be eligible for health insurance coverage under the plan. Your employer can also require new employees to satisfy a waiting period (not to exceed 90 days) before they are eligible for enrollment. All employees who meet theserequirements are eligible to enroll in the plan. Eligibility is not based on any health status-related factors.

Family Members

If you are enrolled in the plan, the following family members are also eligible for enrollment as your dependent:

- Your legal spouse or qualified domestic partner;
- Your children until they attain the age of 26, regardless of the child's place of residence, marital status, or financial dependence on you. For purposes of eligibility for enrollment in the plan, the term "child" means:
    - a biological child of you or your spouse;
    - an adopted child of you or your spouse;
    - a child actually placed with you while adoption proceedings are pending;
    - a child for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO);
    - a child for whom you are legal guardian; and
    - a child of a qualified domestic partner.
- Your siblings, nieces, nephews, or grandchildren under the age of 26 who are unmarried, not in a domestic partnership, registered or otherwise, and for whom you are the court appointed legal custodian or guardian with the expectation that the child will live in your household for at least a year;
- Your, your spouse's or your qualified domestic partner's dependent children age 26 or over who are mentally or physically disabled. To qualify as a dependent, the child must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability;
    - Samaritan Health Plans requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage

To be eligible for coverage as a dependent, a dependent child of divorced parents does not have to qualify as a dependent for Internal Revenue Service tax exemption purposes.

Family or household members other than those listed above are not eligible to be enrolled under your coverage. Dependent parents, foster children, and any other relative not described above are not eligible for coverage under the Plan. Grandchildren are eligible to be enrolled only if they have been adopted or placed with you for adoption, or for whom you have legal guardianship.

How and When to Enroll

When You First Become Eligible

The initial coverage eligibility date for you and your enrolling family members is the first day of the month after you satisfy the waiting period established by your employer. Coverage will only begin if we receive your enrollment application with your employer's premium payment for that month. In order to become enrolled as of that initial eligibility date, you must enroll within the 30 day period following the eligibility date.

If you do not enroll within this initial enrollment period, you must wait until the next open enrollment period to enroll, unless you incur a special enrollment event discussed below.

To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the application to your employer, and your employer will send it to Samaritan Health Plans.

Open Enrollment

The open enrollment period is the only time, other than initial eligibility or a special enrollment period, during which you and /or your eligible dependents may enroll in the plan. You must submit to your employer an enrollment form on behalf of all individuals you want enrolled. If you do not enroll within this open enrollment period, you must wait until the next open enrollment period to enroll, unless you incur a special enrollment event discussed below.

Mid-Year Special Enrollment – Newborns

A newborn baby of you, your spouse, or your qualified domestic partner is eligible for enrollment under the plan during the 30 day period after birth. To add the child to your coverage, you must submit an enrollment application listing the child as your dependent. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. You may be required to submit a copy of the newborn's birth certificate to complete enrollment.

If additional premium for coverage is required, then the baby's eligibility for enrollment will end 30 days after birth if Samaritan Health Plans has not received an enrollment application and the correct premium. Premium is charged from the date of birth, and prorated for the first month.

If no additional premium is required, then the baby's eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Mid-Year Special Enrollment – Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment during the 30 day initial enrollment period after placement for adoption. 'Placement for adoption' means the assumption and retention by you, your spouse, or your qualified domestic partner of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent. You can be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

If additional premium is required, then the child's eligibility for enrollment will end 30 days after placement if Samaritan Health Plans has not received an enrollment application and the correct premium. Premium is charged from the date of placement and prorated for the first month.

If no additional premium is required, then the child's eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Mid-Year Special Enrollment – Family Members Acquired by Marriage

If you marry, you can enroll yourself in the plan (if you are not already enrolled) or you can add your new spouse and any newly eligible dependent children to your coverage. The enrollment must be made during the 30 day period from the date of the marriage. Samaritan Health Plans must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the date of marriage. You can be required to submit a copy of your marriage certificate to complete enrollment.

Mid-Year Special Enrollment – Family Members Acquired by Domestic Partnership

If you are enrolled in the plan, you may enroll a new qualified domestic partner and any eligible dependent children of the domestic partner. The enrollment must be made during the 30 day period from the date of the domestic partnership. Samaritan Health Plans must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new qualified domestic partner and any eligible dependent children of the domestic partner will then begin on the first day of the month after the beginning of the partnership. You can be required to submit information requested by the employer evidencing the qualification of the domestic partnership to complete enrollment.

Mid-Year Special Enrollment – Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible sibling, niece, nephew, or grandchild, you can add that family member to your coverage. To be eligible for coverage, the family member must be:

- Not in a domestic partnership, qualified or otherwise
- Under the age of 26
- Expected to live in your household for at least a year, unless otherwise ordered by court

Samaritan Health Plans must receive your enrollment application and additional premium during the 30 day initial enrollment period beginning on the date of the court appointment. Coverage will then begin on the first day of the month following the date of the court order. You can be required to submit a copy of the court order to complete enrollment.

Enrolling After the Initial Enrollment Period

Returning to Work After a Layoff

If you are laid off and then rehired by your employer within nine months, you will not have to satisfy another probationary waiting period.

Your coverage will resume coinciding with the date of return to work from layoff and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well.

You must re-enroll your family members by submitting an enrollment application to Samaritan Health Plans within the 30 day initial enrollment period following your return to work. Failure to submit the application within the 30 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.

DRAFTER'S NOTE: The language will not be standard. The language will be inserted for those groups who require this language for their processes.

[Returning to Work After a Leave of Absence (LOA)]

[If you return to work after an employer-approved leave of absence of nine months or less, you will not have to satisfy another probationary waiting period.

Your coverage will resume coinciding with the date of return from LOA and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well.

You must re-enroll your family members by submitting an enrollment application to Samaritan Health Plans within the 30 day initial enrollment period following your return to work. Failure to submit the application within the 30 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.]

Other Special Enrollment Events

Your employer may have an agreement with Samaritan Health Plans allowing employees with other health coverage to waive enrollment in the plan. In that case, the employee and family members can decline coverage during the initial enrollment period. If the employee is eligible to decline coverage and wishes to do so, the employee must submit the Enrollment, Change, Waiver form to the employer. The employee and family members can enroll in this plan later if the employee qualifies under rules discussed below.

If the agreement between Samaritan Health Plans and the employer requires all eligible employees to participate in this plan, the employee must enroll during the initial enrollment period. However, the employee's family members can decline coverage, and they can enroll in the plan later if they qualify under rules discussed below.

If you waive coverage under the plan for a year, you must wait until the next open enrollment period to elect coverage under the plan, unless you experience a special enrollment event.

Special Enrollment – Loss of Eligibility for Other Coverage

If the employee declined enrollment for themselves or family members because of other health insurance coverage, the employee or family members can enroll in the plan later if the other coverage ends involuntarily. Family members may enroll as long as the employee enrolls in coverage. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below an employer's minimum requirement, the other insurance plan was discontinued, the other employer's premium contributions toward the other insurance plan ended, or because of death of a spouse or domestic partner, divorce, or legal separation. To do so, the employee must request enrollment within 30 days after the other health insurance coverage ends (or within 60 days after

the other coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

Special Enrollment – Premium Assistance Subsidy

If the employee or the employee's dependents become eligible for a premium assistance subsidy or Medicaid coverage under Medicaid or a State Children's Health Insurance Program (CHIP), the employee can enroll themselves and/or dependents at that time. To do so, the employee must request enrollment within 60 days of the date the employee and/or dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Qualified Medical Child Support Orders (QMCSO)

Samaritan Health Plans will comply with the terms of any QMCSO. A QMCSO is a child support order, judgment or decree (including a court-ordered marital settlement agreement) requiring a group health plan to allow you to enroll the child for medical coverage. An order must meet certain legal requirements to be a QMCSO. Samaritan Health Plans has the sole authority to determine whether those legal requirements have been met. If these requirements have been met, the health plan must provide the coverage required by the order. However, you will be required to make the same contributions for the coverage of the child that is otherwise payable for the coverage of a dependent. You will be notified if your employer receives a QMCSO relating to you. A copy of the QMCSO procedures is available upon request from Member Services. If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you can enroll yourself and/or your newly acquired dependents at that time. To do so, you must request enrollment within 30 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement. Special Enrollment Rule #3

Termination of Coverage

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends as of the end of the period in which you worked full time and for which a premium was paid. You can, however, be eligible to continue coverage for a limited time; see Federal and State Continuation Coverage for more information.

Subject to restrictions imposed by Internal Revenue Code Section 125 and your employer, you can voluntarily discontinue coverage for your enrolled family members at any time by completing an Enrollment Change/Waiver form and submitting it to your employer. Keep in mind that once coverage is discontinued, your family members may not be able to again enroll in the plan until the next enrollment period.

Divorced Spouses or Legal Separation

If you divorce, coverage for your spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify your employer of the divorce or separation, and continuation coverage can be available for your spouse. If there are special child custody circumstances, please contact the Member Services. See Federal and State Continuation Coverage for more information.

Dependent Children

When your enrolled child no longer qualifies as a dependent, coverage will end on the last day of the month in which the dependent attains the age of 26 or otherwise ceases to qualify as an eligible dependent. See “Eligibility and Enrollment” for information on when your dependent child is eligible beyond age 25. See Federal and State Continuation Coverage where you can find more information on other coverage options for those who no longer qualify for coverage.

Dissolution of Domestic Partnership

If you dissolve your qualified domestic partnership, coverage for your domestic partner and their children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the domestic partnership is final. You must notify your employer of the dissolution of the domestic partnership. Continuation coverage may be available for your domestic partner and their covered children. See Federal and State Continuation Coverage for more information.

If You Die

Coverage for your dependents will end on the last day of the month in which your death occurs. However, your dependents may extend their coverage on a self-pay basis. Refer to the Federal and State Continuation Coverage section for details on the extended coverage.

Federal and State Continuation Coverage

Under federal and state laws, you and your family members can have the right to continue this plan's coverage for a specified time.

The following sections describe your rights to continuation under federal and state laws, and the requirements you must meet to enroll in continuation coverage.

Federal COBRA Continuation

If your employer has 20 or more employees, you and/or your spouse and eligible dependents may be eligible to continue your health care coverage on a self-pay basis under certain qualifying events. This continuation coverage is made available pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

DRAFTERS NOTE: Language will populate for groups who choose to extend independent COBRA rights to domestic partners

[A domestic partner who was covered at the time of the qualifying event may elect COBRA continuation coverage. Domestic partners have the same COBRA rights as a spouse. Where this section refers to divorce or legal separation, termination of domestic partnership applies.]

The following sections describe your rights to continuation under COBRA, and the requirements you must meet to enroll in continuation coverage. If you have questions about your COBRA continuation coverage, you should contact your employer.

You, your spouse and your dependents, as applicable, may only continue the health coverage that was in effect when the qualifying event took place. The coverage will be the same as that provided under the plan for active employees.

A child who is born to or adopted by you while you are receiving continuation coverage is also entitled to continuation coverage. Written notice of a child born to or adopted by you while you are receiving continuation coverage must also be provided to the employer within 60 days of that event.

Individuals entitled to COBRA continuation coverage have the same rights afforded similarly-situated plan members who are not enrolled in COBRA. COBRA participants may add newborns, a new spouse, and adopted children (or children placed for adoption) as covered dependents in accordance with the plan's eligibility and enrollment rules, including the plan's special enrollment rules.

Qualifying Events

A "qualifying event" is the event that causes your regular coverage under the plan to end and makes you eligible for continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if they lose coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than for gross misconduct; or
- You become divorced or legally separated.

Your covered eligible children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than for gross misconduct;
- You become divorced or legally separated from your spouse; or
- Your child is no longer eligible for coverage under the plan.

Notification of Qualifying Event – Your Responsibility

In the event of your divorce or legal separation of the employee and spouse, or an eligible child's losing eligibility for coverage as an eligible child, you must notify your employer within 60 days after the qualifying event occurs. Your notice must include the nature and date of the qualifying event, the name of the person losing coverage, and a mailing address for that person. The plan will offer COBRA continuation coverage to qualified beneficiaries only after the employer has been timely notified that a qualifying event has occurred.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse or domestic partner, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]

[1] If the employee or covered dependent is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, separation, , death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.

When the qualifying event is the death of the employee, divorce or legal separation, or an eligible child's losing eligibility as an eligible child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for the employee’s spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended, which are detailed below.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled and you notify the employer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

In order to be eligible for this extended continuation coverage period, the disabled individual (or someone on the individual’s behalf) must notify the employer of the SSA disability determination within 60 days of the issuance of the determination by the SSA (or, if later, within 60 days of the end of the month in which the employee terminates employment or transfers to part-time status) and before the end of the otherwise applicable 18-month continuation period, whichever period ends first. The notice must include a copy of the SSA determination. If the notice of the SSA determination is not provided to the employer within this time period, then the 11-month extension of coverage will not be available.

If the SSA later makes a final determination that the individual is no longer disabled, the individual must notify the employer within 30 days of the final determination by the SSA.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and eligible children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any eligible children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the eligible child stops being eligible under the plan as a eligible child, but only if the event would have caused the spouse or eligible child to lose coverage under the plan had the first qualifying event not occurred.

In all cases, you must make sure that the employer is notified of the second qualifying event within 60 days of the second qualifying event. Your notice must include the nature and date of the second qualifying event, the name of the person losing coverage, and a mailing address for that person.

Once Notification is Given

When the employer is notified that one of the above events has occurred, you will receive notice that you or your covered dependents of the right to elect continuation coverage. Under this provision, the COBRA-eligible person must elect continuation coverage within 60 days from the date coverage would otherwise be lost because of one of the events described above or 60 days from the date of notification of your COBRA rights, whichever is later. Failure to elect continuation coverage within that period will cause coverage under the plan to end as it normally would under the terms of the plan.

Cost of COBRA Continuation Coverage

You or your covered dependent is responsible for the full cost of continuation coverage and any administrative fee assessed. Payment for continuation coverage for any month is due on the first day of the month, or as of such later day established by your employer. The only exception is the premium payment for continuation coverage during the period preceding the election, which must be made within 45 days of the date of election or a later date allowed by the employer. Premium rates may change annually.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will end for a person (i.e., you, your spouse, domestic partner, or dependent, as applicable) if one of the following events occurs:

- Failure to timely pay the full required continuation premium
- The employer no longer offers group health coverage
- The person later becomes covered under any other group health plan. However, coverage under another plan will not cause continuation to end if the other plan excludes or limits coverage for a pre-existing condition of the person
- The person later becomes entitled to Medicare benefits under Part A, Part B, or both
- In the case of a person who qualified for an extra 11 months continuation coverage based on the disability and persons receiving continuation coverage by reference to such disabled person, the date of a final determination by the Social Security Administration that the person is no longer disabled
- The applicable period of continuation ends
- Coverage is terminated for cause (e.g., a member submits a fraudulent claim)

Continuation coverage may also be terminated for any reason the plan would terminate coverage of an employee or dependent not receiving continuation coverage. Once COBRA continuation coverage ends, it cannot be reinstated.

Oregon State Continuation

Under this plan, you can have continuation coverage rights under Oregon state law.

State Continuation Eligibility When Employer Has Less than 20 Employees

If your employer has fewer than 20 employees, or if your group is not subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, you can continue your coverage for up to nine months. You and your enrolled family

members can continue coverage if you, the employee, no longer qualify for coverage under the plan (for example, if your work hours are reduced or you quit your job).

Your spouse and dependent children can also continue coverage under this plan if you divorce, become eligible for Medicare benefits that results in a loss of coverage, or die. Your children can also continue coverage under this plan if they no longer qualify as a dependent under the terms of this plan. Continuation coverage can last a maximum of nine months. Premium for continuation coverage is the responsibility of you or your family member. The following restrictions also apply to anyone electing Oregon continuation coverage:

- To qualify for continuation, you must have been covered under the plan for at least three months before the date of the qualifying event. If your employer recently switched to this Group Policy from another group health plan without a break in coverage, you will receive credit for time under the previous plan.
- Family members who were not enrolled in the group plan cannot elect continuation. The only exceptions are newborn babies and newly acquired dependents not covered by another group health plan.
- To apply for continuation, you must submit to your employer a completed State Continuation Coverage Election Form within ten days after the date on your continuation notice or the date of your qualifying event, whichever is later.
- You must pay continuation premiums to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you.
- Your employer must still be insured by Samaritan Health Plans. If the Group Policy is discontinued by your employer or otherwise terminated, you will no longer qualify for continuation through this Group Policy.

When State Continuation Coverage Ends

Although Oregon continuation coverage can last up to nine months, coverage will end early if any of the following occurs:

- If you do not pay the premium to your employer on time, coverage will end on the last day of the last month for which you paid a premium.
- If you become eligible for Medicare, your coverage will end on the last day of the month prior to the Medicare eligibility date.
- If your employer discontinues this Group Policy, your coverage will end on the last day the policy was in effect.
- If you and your dependents become eligible for another group health plan (such as a spouse's employer's plan or a plan at your new job), your coverage will end on the date you become eligible for that plan.

Type of Coverage

Under Oregon continuation, you can continue the coverage you had before the qualifying event. Oregon continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the plan will also apply to everyone enrolled in continuation coverage. We can provide you uninterrupted coverage when the existing Group Policy is replaced.

Continuation for Spouses over Age 55

Subject to the general provision of the plan, if you die, become divorced orlegally separated and your covered spouse is then age 55 or over, your spouse and any other covered dependents may continue medical coverage under the plan on a self-pay basis until the earliest to occur of the following events:

- Failure to pay premiums when due;
- Termination of the Group Policy, unless another group health plan is made available by the employer to its employees;
- Your legally separated, divorced or surviving spouse becomes covered under another group health plan or becomes eligible for Medicare; or
- Covered dependents no longer meet the eligibility requirements of the plan.

In order to be eligible for continued coverage, your spouse or dependent must give written notice of the legal separation, termination of marriage or domestic partnership, or death of the employee to the employer within:

- Thirty days of the date of the employee's death
- Sixty days of the date of legal separation
- Sixty days of the date of entry of the divorce decree

DRAFTERS NOTE: Language will populate based on whether the group chooses to extend independent state continuation of coverage rights only to registered domestic partners as required by state law (the first clause below), or optionally, to other classes of domestic partners, such as opposite sex domestic partners (the second clause below).

[A registered domestic partner who was covered at the time of the qualifying event may elect state continuation of coverage. Registered domestic partners have the same state continuation of coverage rights as a spouse. Where this section refers to divorce or legal separation, termination of domestic partnership applies.]

[A domestic partner, who was covered at the time of the qualifying event, may elect state continuation of coverage. Domestic partners have the same state continuation of coverage rights as a spouse. Where this section refers to divorce or legal separation, termination of domestic partnership applies.]

USERRA Continuation

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA). You and your enrolled family members can continue this plan's coverage if you, the employee, no longer qualify for coverage under the plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility. The following requirements apply to USERRA continuation:

- Family members who were not enrolled in the plan cannot take continuation. The only exceptions are newborn babies and newly acquired dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election Form to your employer within 30 days after the last day of coverage under the group plan.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you.
- Your employer must still be insured by Samaritan Health Plans. If this Plan is discontinued by your employer or otherwise terminated, you will no longer qualify for continuation through Samaritan Health Plans.

Continuation After Injury or Illness Covered by Workers' Compensation

If you have an injury or illness covered by workers' compensation, you may continue your coverage under this plan by self-paying the health plan premium until the earliest of the following dates:

- You take full-time employment with another employer
- Six months from the date you first pay your health insurance premium under this provision
- Continuation under this provision will be concurrent with COBRA continuation for the period that you are also eligible for COBRA continuation.

Work Stoppage

Labor Unions

If you are a union member, you have certain continuation rights in the event of a labor strike or lockout. Your employer is responsible for collecting your premium and can answer questions about coverage during the strike.

Plan Benefits

This Plan pays for vision examinations, and corrective lenses and frames when prescribed by a licensed ophthalmologist or licensed optometrist, for you and your insured dependents. The Plan allows you to choose any licensed ophthalmologist, optometrist or optician. However, there is a difference in member cost share for in-network vision providers and out-of-network vision providers.

Deductible

There is **no deductible** for covered vision services or supplies and the benefits are paid, up to the maximum limit listed in your Benefit Schedule. These vision care benefits are provided on a calendar year basis.

Covered Benefits

Eye Examinations: One comprehensive eye exam per calendar year. See your Benefit Schedule for your cost share.

Vision Hardware and/or Accessories:

- Single Vision lenses
- Lined bifocal lenses
- Lined trifocal lenses
- Progressive lenses are covered, if prescribed and billed appropriately by a licensed provider and for a diagnosis not excluded in our plan
- Polycarbonate Lenses
- Contact Lenses
- Frames

Limitations and Exclusions

The vision care benefit will only pay for the items listed above up to the maximum limit per individual and per calendar year.

Exclusions

The following are not covered benefits under this Plan:

- Any cost which is in excess of the allowed amount
- Medical or surgical treatment of the eyes
- Visual fields testing
- Contact lens or eyeglass fitting fees
- Orthoptics or vision training
- Lenticular lenses
- Subnormal vision aids
- Aniseikonic lenses
- High index lenses other than polycarbonate
- Lens extras, such as photochromic lenses and anti-glare coatings
- Hardware repairs
- Nonprescription or Plano lenses
- Extra charges for fashion eyewear features such as blended bifocals, flash coated, oversize lenses, or more than the standard cost for frames

- Services and supplies that are payable under a workers' compensation or occupational disease law
- Any eye examination required as a condition of employment
- Duplication or replacement eyeglasses, lenses or frames
- Any expense paid in whole or in part by any other provision of the Group Plan provided by the Policyholder
- Experimental or investigational vision services are excluded under the same standards as the medical benefits

Claims Information

When a claim is submitted for payment every attempt will be made to process it promptly and accurately. Claims must be submitted within one year (365 days) of the time the covered person receives the service or supply to be eligible for payment. We reserve the right to examine, at our own expense, the insured when and as often as it can reasonably require when a claim is pending.

Within 30 days of receipt of a clean claim, the claims administrator will process your claim. We will report this information to you on a form called an Explanation of Benefits (EOB). The plan can pay claims, deny them, or accumulate them toward satisfying the deductible (if applicable). If Samaritan Health Plans denies all or part of a claim, the reason or reasons for the action will be stated in the EOB. The explanation will also contain the following items:

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

If a member receives payment for a benefit that he or she is not eligible to receive, the plan has the right to recover the payment from the member (including by reducing future claim payments for the member) or anyone else who benefits from it. The covered person has the right to appeal claims decisions that they do not agree with. See Appeals and Grievances.

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

Samaritan Health Plans
PO Box 887
Corvallis, OR 97339

Member Claim Reimbursements

Payee of Claims

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the plan has died, is a minor or is incompetent, we can pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Samaritan Health Plans' obligations under the plan.

Notice of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at PO Box 887 Corvallis, OR 97330, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Determinations

Within 30 days of our receipt of a clean claim, we will notify you of the action we have taken on it, adverse or not. However, this 30 day period can be extended by an additional 30 days in the following situations:

- When we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30 day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to act on the claim.
- When we cannot take action on the claim due to lack of information, we will notify you within the initial 30 day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You must provide us with the requested information within 30 days of receiving the request for additional information. If we do not receive the requested information to process the claim within the 60 days we have allowed, we will deny the claim.

Time Frames for Processing Claims

If Samaritan Health Plans denies your claim we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information from you to complete our processing of your claim, we will send you a separate request for information and you will have 45 days to submit the additional information. Once we receive the additional information from you we will complete our processing of the claim within 30 days.

Medicare

In certain situations, this plan is primary to Medicare. When you are covered by Medicare and this plan at the same time and if this plan is primary, the plan pays benefits for eligible charges first and Medicare pays second in specific situations. Those situations are:

- When you or your spouse is age 65 or over and by law Medicare is secondary to the plan;
- When you or your covered dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to the plan; and
- When you or your covered dependent is entitled to benefits under section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to the plan.

For additional information on how this plan coordinates with Medicare, please see www.medicare.gov.

Coordination of Benefits

Coordination of this Group Contract's Benefits with Other Benefits

This Coordination of Benefits (COB) section applies when a member has health care coverage under more than one plan. The term "plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The

plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan can cover some expenses. The plan that pays after the Primary plan is the Secondary plan. The Secondary plan can reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expenses.

Definitions Relating to Coordination of Benefits

The following are definitions that apply to this Coordination of Benefits Section.

Plan – Plan means any of the following that provides benefits or services for medical, care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

Coordination – When this plan is Primary, we determine payment for our benefits first before those of any other plan without considering any other plan's benefits. When this plan is Secondary, we determine our benefits after those of another plan and can reduce the benefits we pay so that all plan benefits do not exceed 100% of the total allowable expenses.

Allowable Expenses – Allowable expense means a health care cost, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering a member. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. A charge that is not covered by any plan covering a member is not an allowable expense. In addition, any charges that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

Closed Panel Plan

A closed panel plan is a plan that provides health care benefits to members primarily in the form of services through a panel of providers that has contracted with or is employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a contracted provider. Samaritan Small Group Benefit Plan is not a closed panel provider plan.

Custodial Parent

A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the dependent child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan. Except as provided in the bullet below, a plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed panel plan to provide out-of-network benefits.

A plan can consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

Each Plan Determines its Order of Benefits Using the First of the Following Rules that Apply:

Non-Dependent or Dependent

The plan that covers a member other than as a dependent, for example as an employee, subscriber or retiree is the Primary plan and the plan that covers the member as a dependent is the Secondary plan. However, if the member is a Medicare beneficiary, and as a result of federal law, Medicare is secondary to the plan covering the member as a dependent; and primary to the plan covering the member as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the member as an employee, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

Dependent Child Covered Under More than One Plan

Unless there is a court decree stating otherwise, when a member is a dependent child and is covered by more than one plan the order of benefits is determined as follows:

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan or;
   ii. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary plan.

(B) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This subparagraph does not apply with respect to

any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (A) of this subsection determines the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of paragraph (A) of this subsection determines the order of benefits; or

iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    I. The plan covering the custodial parent

    II. The plan covering the custodial parent's spouse

    III. The plan covering the non-custodial parent

    IV. The plan covering the non-custodial parent's spouse

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the dependent child, the provisions of subparagraph (A) or (B) above shall determine the order of benefits as if those individuals were the parents of the dependent child.

Active Employee or Retired or Laid-Off Employee

The plan that covers a member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The plan covering that same member as a retired or laid-off employee is the Secondary plan. The same would hold true if a member is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled Order of benefit determination rules can determine the order of benefits.

COBRA or State Continuation Coverage

If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, subscriber or retiree or covering the member as a dependent of an employee, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled Order of benefit determination rules can determine the order of benefits.

Longer or Shorter Length of Coverage

The plan that covered the member as an employee, subscriber or retiree longer is the Primary plan and the plan that covered the member the shorter period of time is the Secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expense shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than we would have paid had we been the primary plan.

Effect on the Benefits of this Plan

When this Plan is Secondary, we can reduce our benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expense. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The Secondary plan can then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expenses for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a member is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one closed panel plan; COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under this Plan and other plans. We can get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under this Plan and other plans covering a member claiming benefits. We need not tell, or get the consent of, any person to do this. Each member claiming benefits under this Plan must give us any facts we need to apply this section and determine benefits payable.

Facility of Payment

A payment made under another plan can include an amount that should have been paid under this Plan. If it does, we can pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB section, we can recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that can be responsible for the benefits or services provided for the member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Other Claims Recoveries

If we mistakenly make a payment for you or your covered dependent to which you or your covered dependent is not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefits from it, including a provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any of your covered dependents even if the mistaken payment was not made on that person's behalf.

We regularly engage in activities to identify and recover claims payments, which should not have been paid (for example, claims which are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit to your group's experience or the experience of the pool under which your group is rated all amounts that we recover, less our reasonable expenses in getting the recoveries. At our own expense, have the right and opportunity to examine you or the covered dependent when and as often as it can reasonably require while a claim is pending.

If you have questions, please contact our Member Services Department by calling:

Member Services Department
541-768-4550
toll-free at 1-800-832-4580
TTY 1-800-735-2900
Monday through Friday 8 a.m. to 8 p.m.

Member Grievance and Appeals Review

Complaints, Grievances and Appeals

If you have questions or concerns about your benefits, the quality of care you receive, or how quickly and informally the claims administrators reached a decision or handled a claim, please contact Member Services. We may be able to resolve an issue quickly and informally.

Filing a Grievance

You or your Authorized Representative can file your grievance verbally or, in writing. Within five (5) business days of receiving a grievance, we will send you or your authorized representative an acknowledgment letter. If the grievance cannot be resolved within five business days, 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.

Filing an appeal

You or your authorized representative may submit an appeal of an adverse benefit determination. 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 can use an Appeal Request Form to provide this information.

Within five (5) business days of receiving the appeal, we will send you or your authorized representative an acknowledgment letter. You or your authorized representative has the right to appear in person to talk about your appeal. The Level 1 appeal decision will be determined by a healthcare professional not previously involved in your initial adverse benefit determination. You or your authorized representative will receive a written decision within 30 days of our receiving your appeal request.

HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your protected health information (PHI).

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your protected health information, or if you wish to file a complaint under HIPAA, please contact:

Member Services Department
541-768-4550
Toll-free at 1-800-832-4580
TTY 1-800-735-2900
Monday through Friday 8 a.m. to 8 p.m.

Who Will Follow the Privacy Rules

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

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

Our Pledge Regarding Medical Information

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

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

We are required by law to:

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

How We May Use and Disclose Medical Information About You

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

For Treatment

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

For Payment

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

For Health Care Operations

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

Treatment Alternatives

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

Health-Related Benefits and Services

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

Individuals Involved in Your Care or Payment for Your Care

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your

family can be notified about your condition, status, and location. You do have the right to object to the sharing of this information.

Research

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

As Required by Law

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

To Avert a Serious Threat to Health or Safety

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

Personal Representative

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

Military and Veterans

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

Workers Compensation

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

Public Health Risk

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

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

Health Oversight Activities

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

Lawsuits and Disputes

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

Law Enforcement

We may release medical information to a law enforcement official:

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

Coroners, Medical Examiners, and Funeral Directors

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

National Security and Intelligence Activities

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

Protective Services for the President and Others

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

Inmates

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

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

Written Authorization

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

Your Rights Regarding Medical Information About You

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

Protection of Genetic Information

Genetic information about you or your family members may not be used or disclosed for activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, or for any other underwriting purpose.

Notification of Breach of Unsecured Health Information

You will be promptly notified if SHPO or a business associate discovers a breach of unsecured health information that affects you.

Right to Inspect and Copy

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

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

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

Right to Amend

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

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

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

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

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

Right to an Accounting of Disclosures

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

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

Right to Request Restrictions

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

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

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

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

Right to Request Confidential Communications

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

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

Right to a Paper Copy of this Notice

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Samaritan Health Plan Operations. Please refer to your Member Handbook or Evidence of Coverage for contact information. You also may file a complaint with the U.S. Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be retaliated against for filing a complaint.

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

You will not be penalized for filing a complaint.

Changes to this Notice

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

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

Denise Severson
Samaritan Health Plans Compliance Officer

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

Or write to:

Samaritan Health Plans
PO Box 1310
Corvallis, OR 97339

Effective date

This HIPAA Privacy Notice is effective as of January 1, 2019.

Your Rights and Responsibilities

In accordance with Oregon law, the following Disclosure Statement includes questions and answers to fully inform you about the benefits and policies of this plan.

Your Rights as a Member

- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of your dignity and right to privacy.
- A right to participate with your healthcare provider in making decisions regarding your care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- You have a right to the confidential protection of your medical information and records.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- You have the right to continue care from an individual provider for a limited period of time after the medical services contract terminates.

Your Responsibilities as a Member

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that you have agreed to with your practitioners.
- A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- A responsibility for payment of copays at the time of service and to be on time for that service.
- A responsibility 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.

How do I access care in the event of an emergency?

If you experience an emergency situation, you should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether you require emergency treatment, you can always call your primary care provider for advice. The primary care provider is able to assist you in coordinating medical care and is an excellent resource to direct you to the appropriate care since he or she is familiar with your medical history.

How will I know if my benefits change or are terminated?

Samaritan Health Plans will notify you of changes or termination of coverage 30 days prior to the effective date of change or termination. We have the right to make changes that are in the best interest of its members and/or its independent contractors.

What happens if I am receiving care and my doctor is no longer a contracted provider?

When a professional provider's contract with us ends for any reason, we will give notice to those covered that we know are under the care of the provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than 10 days after the provider's termination date or 10 days after the date we learn the identity of an affected covered individual, whichever is later. The exception to our sending the notice is when the professional provider is part of a group of providers and we have agreed to allow the provider group to provide continuity of care notification to those covered.

When Continuity of Care Applies

If you are undergoing an active course of treatment by an in-network professional provider and benefits for that provider would be denied (or paid at a level below the benefits for an out-of-network provider) if the provider's in-network contract with us is terminated or the provider is no longer participating in our in-network provider network, we will continue to pay Plan benefits for services and supplies provided by the professional provider as long as:

- You and the professional provider agree that continuity of care is desirable and you request continuity of care from us
- The care is medically necessary and otherwise covered under the plan
- You or your covered dependent remains eligible for benefits and covered under the plan
- The Plan has not terminated

Continuity of care does not apply if the contractual relationship between the professional provider and us ends in accordance with quality of care provisions of the contract between the provider and us or because the professional provider:

- Retires
- Dies
- No longer holds an active license
- Has relocated outside of our service area
- Has gone on sabbatical
- Is prevented from continuing to care for patients because of other circumstances

How Long Continuity of Care Lasts

Except as follows for pregnancy care, we will provide continuity of care until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling you to continuity of care is completed; or the 120th day after notification of continuity of care.

If you become eligible for continuity of care after the second trimester of pregnancy, we will provide continuity of care for that pregnancy until the earliest of the following dates:

- The 45th day after the birth.
- The day following the date on which the active course of care treatment entitling you to continuity of care is completed; or
- The 120th day after notification of continuity of care.

The notification of continuity of care will be the earliest of the date we or, if applicable, the provider group notifies you of your right to continuity of care, or the date we receive or approve the request for continuity of care.

Medical Necessity of Continuing Care

If questions arise about the medical necessity of continued care for treatment or services, the plan can ask the attending physician to provide evidence supporting the need for this care. The plan can discontinue payment of benefits if the medical information from your physician does not clearly indicate that continued care for treatment or services is medically necessary.

Quality of Medical Care

The covered person always has the right to choose his or her own hospital or physician. The plan is not responsible for the quality of medical care the covered person receives. The plan cannot be held liable for any claims for damages connected with injuries suffered by the covered person while receiving medical services and supplies.

Complaint and Appeals:

If I am not satisfied with my health plan or provider what can I do to file a complaint or get outside assistance?

To voice a complaint with us, simply follow the process outlined under Member Grievance and Appeals, including, if applicable, information about filing an appeal to be reviewed by an independent physician without charge to you.

You also have the right to file a complaint or seek other assistance from the Division of Financial Regulation.

By calling: 503-947-7984 or the toll free message line at 888-877-4894

By electronic mail at: cp.ins@oregon.gov

By writing: Oregon Division of Financial Regulation
Consumer Advocacy Unit at:
PO Box 14480; Salem, OR 97309-0405

Consumer Advocacy website: https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

How are important documents (such as my medical records) kept confidential?

We have a written plan to protect the confidentiality of health information. Only employees who need to know in order to do their jobs can access your personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing you coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from you or your authorized representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

My neighbor has a question about the Plan that he has with you and doesn't speak English very well. Can you help?

Yes. Simply have your neighbor call our Member Services Department at the number on his or her identification card. One of our representatives will coordinate the services of an interpreter over the phone. We can help with sign language as well as spoken languages.

What additional information can I get from you upon request?

The following documents are available by calling our Member Services Department:

- Rules related to our medication formulary, including information on whether a particular medication is included or excluded from the formulary and information on what medications require pre-authorization from Samaritan Health Plans.
- Provisions for behavioral health services, and hospital services, and how you can obtain the care or services.
- A copy of our annual report on complaints and appeals.
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration.
- A description of our efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care.
- Information about our prior authorization and utilization review procedures.

What other source can I turn to for more information about your company?

The following information regarding the plans of Samaritan Health Plans is available from the Division of Financial Regulation:

- The results of all publicly available accreditation surveys
- A summary of our health promotion and disease prevention activities
- Samples of the written summaries delivered to plan holders
- An annual summary of grievances and appeals
- An annual summary of utilization review policies
- An annual summary of quality assessment activities
- An annual summary of scope of network and accessibility of services

To obtain the mentioned information, contact the Oregon Division of Financial Regulation:

By calling (503) 947-7984 or the toll free message line at (888) 877-4894

By electronic mail at: cp.ins@oregon.gov
By writing Oregon Division of Financial Regulation
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PO Box 14480
Salem, OR 97309-0405

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Plan Administration

Governing Law

The interpretation and validity of this contract will be governed by the laws of the State of Oregon without regard to its conflict of law rules, and by applicable Federal Law. If there is conflict between the provisions of this Plan and Oregon State or Federal Laws, Oregon State or Federal Laws will take precedence over the provisions of this Plan.

Compliance with State and Federal Mandates

The plan will provide benefits in accordance with the requirements of all applicable state and federal laws. These laws may be amended from time to time. In the event of any conflict between the provisions of the plan and the current provisions of the law, the current provisions of the law will govern.

Other Authorities and Responsibilities

Samaritan Health Plans is not the named fiduciary, plan sponsor, or plan administrator under ERISA of the plan. Samaritan Health Plans does not have discretionary authority with regards to administration of the plan and does not make member eligibility determinations.

Samaritan Health Plans may make factual determinations relating to benefits provided under the plan. Samaritan Health Plans may delegate this discretionary authority to other persons or entities that may provide administrative services for the plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time.

A member cannot assign any benefit or money due under this plan to any other person, medical service or supply provider, corporation, or any other organization. Any attempted assignment will be void and of no effect. For purposes of this provision, an "assignment" refers to the transfer of your rights to the benefits described in this plan, to any other person, corporation, or other organization or entity.

Changing this Certificate

The plan as described in this Certificate explains the benefits available to you under a Group Policy contract entered into by and between Samaritan Health Plans and your employer (the policyholder). The contract between Samaritan Health Plans and your employer contains additional information regarding eligibility and benefits available under the plan. No prior inducements, either orally or in writing, are of any force or effect unless they are included in this document or the contract between Samaritan Health Plans and your employer. Your employer is responsible for setting eligibility and enrollment requirements and Samaritan Health Plans is responsible for the payment of claims under the plan. Please contact your employer for additional information on the contract between Samaritan Health Plans and your employer.

No change in this Group Policy shall be valid until approved by an executive officer of Samaritan Health Plans and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions.

Group Contract Renewal and Termination

The Group Policy governing will renew automatically from year to year unless terminated by the employer as otherwise provided in the group contract. Samaritan Health Plans will only terminate the Group Policy in the event of nonpayment of premiums, fraud, violation of participation or contribution rules, termination of the plan, the employer moves outside the service area, or membership in an association ceases. Termination of the employer under the contract will completely end all obligations of Samaritan Health Plans to provide the members with benefits after the date of termination.

If the employer terminates the Group Policy, the employer must provide Samaritan Health Plans with written notice of termination. Samaritan Health Plans must receive the notice at least 30 days in advance of the proposed termination date. The employer must provide in writing whether Samaritan Health Plans is being replaced by another group policy. The employer shall continue to be liable for plan premiums for all members enrolled in plan through the end of the first full month requested and agreed upon termination date.

Rescinding Coverage

Coverage can be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the Group Policy. We will provide at least 30 days advance written notice to each covered employee who would be affected prior to rescinding coverage. Rescissions are defined as any retroactive cancellations of coverage, except for those attributable to failure to pay premiums or contributions. These requirements do not apply to prospective cancellations.

Samaritan Health Plans may not rescind the plan unless:

(a) The employer:
    A. Performs an act, practice or omission that constitutes fraud
    B. Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;
(b) Samaritan Health Plans provides at least 30 days' advance written notice, in the form and manner prescribed by the Oregon Division of Financial Regulation, to each member who would be affected by the rescission of coverage; and
(c) Samaritan Health Plans provides notice of the rescission to the Oregon Division of Financial Regulation in the form, manner and time frame prescribed by the Oregon Division of Financial Regulation by rule

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

We acknowledge that misstatements, misrepresentations, omissions, or concealments on the part of the insured are not fraudulent unless they are made with intent to knowingly defraud. In order for Samaritan Health Plans to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the employer, we must show that the misinformation is material to the content of this contract, that we relied upon the misinformation *and* that the information was either material to the risk assumed by us *or* that the misinformation was provided fraudulently.

No claim for loss incurred or disability, as defined in the Certificate, commencing after two years from the date of issue of this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the Group Policy.

Relationship to Samaritan Health Services

The group on behalf of itself and its covered participants hereby expressly acknowledges its understanding that this plan constitutes a plan solely between the employer group and Samaritan Health Plans. Neither Samaritan Health Plans, nor Samaritan Health Services is acting as the Plan Administrator or Plan Sponsor under ERISA. The employer on behalf of itself and its covered participants further acknowledges and agrees that it has not entered into this Plan based upon representations by any person or entity other than Samaritan Health Plans and that no person or entity other than Samaritan Health Plans shall be held accountable or liable to the employer or the members for any of our obligations to the employer or the members created under this Plan. This paragraph shall not create any additional obligations whatsoever on the part of Samaritan Health Plans other than those obligations created under other provisions of this Plan.

Inmates and Juveniles in Detention Centers

We will not deny reimbursement for any service or supply covered by the plan nor will we cancel the coverage of a member under the plan on the basis that:

- The insured is in the custody of a local supervisory authority, if the insured is in custody pending the disposition of charges
- The insured receives publicly funded medical care while in the custody of a local supervisory authority
- The care was provided to the insured by an employee or contractor of a county or a local supervisory authority, if the employee or contractor meets the credentialing criteria of the health benefit plan

Confidential Communication

A member has the right to have protected health information sent directly to the member instead of the person who pays for your health insurance plan. A member can request that they be contacted:

- At a different email address
- By email
- By telephone

To make this request, submit the Oregon Request for Confidential Communication standardized form to:

Samaritan Health Plans
P.O. Box 1310
Corvallis, OR 97339

Your health plan must acknowledge the receipt of the request form and respond to your confidential communications request. If you have any questions, please contact Member Services.

Member Services Department

The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs. Come see us at 2300 NW Walnut Boulevard or contact us at:

Please call our Member Services Department or visit www.samhealthplans.org to verify the network status of your provider before getting services. Contact us at 541-768-4550; toll free1-800-832-4580 or TTY 1-800-735-2900. Monday through Friday. We look forward to serving you.

Statements made by applicants, policy holder or insured are representations and not warranties.

Samaritan Health Plans
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Corvallis, OR 97339
www.samhealthplans.org