Samaritan Health Plans

Samaritan Health Plans, Inc.

2019 Vision Plan changes

EFFECTIVE
1/1/2019

Section and Page	2018 Certificate	2019 Certificate	Summary of change
	This document and any endorsements, riders, amendments, applications or attached papers, if any, describes the Vision benefit coverage for eligible participants. We guarantee coverage based on eligibility and provisions of this document, not based on health status, race, creed, genetic information, disability, or sexual orientation. 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 and Oregon Revised Statutes. This policy may be canceled by the insurer only for a reason permitted by law.	**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. Samaritan Health Plans guarantees coverage based on eligibility and provisions of this document, not based on health status, race, creed, disability, or sexual orientation. 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.	Updated language.
Alternate Format Information	If you need this certificate or other informational materials in another form, such as: • Other languages • Large print • Braille • Audio tape • Computer disk • Oral presentation Please call Samaritan Health Plans Member Services Department at (541) 768-4550; 1-800-832-4580 or TTY 1-800-735-2900 to request the format you need. Translations (English)		Removed.

	If you need this booklet in another language, large print, Braille, on tape, or another format, call (541) 768-4550; 1-800-832-4580 or TTY 1-800-735-2900. (Spanish) Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al (541) 768-4550; 1-800-832-4580 o al 1-800-735-2900 (TTY). (Russian) Если Вам нужна эта брошюра на другом языке, напечатанная большими буквами, шрифтом Брайля, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону (541) 768-4550; 1-800-832-4580 или телетайпу 1-800-735-2900.		
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	Added.

		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.	
Definitions page 1		**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.	Added.
Definitions page 1	**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	**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	Updated language.

	indicated by the Explanation of Benefits. Contracted 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. May also be called 'eligible expense', 'payment allowance', or 'negotiated rate'.	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.	
Definitions	**Annual enrollment** – A period of time each year when eligible employees who did not enroll themselves or their eligible dependents within their initial 30 day eligibility period can enroll in the Plan or make Plan changes.		Removed.
Definitions page 1	**Appeal** – A request for your health insurer or Plan to review a decision or a grievance again. A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).		Removed.
Definitions page 1		**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.	Added.
Definitions page 1		**Authorized Services –** Means services or supplies that have been approved by the claims administrator.	Added.
Definitions page 1	**Balance billing** – When a provider bills you for the balance remaining on the bill that your 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 $200 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 (non-preferred provider). An in-network provider (preferred provider) may not bill you for covered services.	**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.	Updated language.
Definitions page 1	**Benefit year –** The benefit year for a group's coverage is based on when an employer group signs an employer group contract.	**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.	Updated language.
Definitions page 1	**Calendar year** – The 12-month period starting on each January 1st and ending on the next December 31st each year.	**Calendar year –** The 12-month period starting on each January 1st and ending on the next December 31st of the same year.	Updated language.
Definitions	**Certificate of coverage** – Written legal description of the plan, also called your certificate or policy. This document is		Removed.

	your written legal description of the vision plan.		
Definitions page 1	**Claim** – A request for payment under the terms of this Plan. A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.	**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.	Updated language.
Definitions page 1		**Claims administrator** – Samaritan Health Plans serves as the claims administrator with respect to claims made under this plan.	Added.
Definitions page 2		**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.	Added.
Definitions	**Cosmetic** – Services and supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem without improving function.		Removed.
Definitions	**Covered expenses** – The amounts that this Plan pays for covered services.		Removed.
Definitions	**Covered person** – A covered employee or a covered dependent who has completed the enrollment requirements and for whom applicable contribution or payroll deduction has been made in the current month.		Removed.
Definitions page 2		**Covered services** – A service or supply that is specifically described as a benefit of this plan.	Added.
Definitions page 2	**Deductible** – The portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide payment for benefits. See the **Out of pocket limits and deductibles** section for more information. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year.	**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.	Updated language.
Definitions page 2		**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.	Added.
Definitions page 2	**Eligibility** – The requirements that you must meet in order to qualify for and remain in your plan option and is not based on Medicaid.	**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.	Updated language.

Definitions page 2	**Eligible employee** – An employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.	**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: • 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.	Updated language.
Definitions page 3	**Employer** – Participants and beneficiaries can receive from the Plan Administrator, upon written request, a complete list of affiliated entities adopting the Plan. Employer also means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.	**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.	Updated language.
Definitions	**Enrollee** – An employee or dependent of the employee eligible for this plan who has enrolled for coverage under this agreement. Enrollee is referred to as subscriber or member.		Removed.
Definitions	**ERISA** – The Employee Retirement Income Security Act of 1974, as amended. ERISA applies to a group health plan unless it is sponsored by a church or government body (or other plan exempted by statute).		Removed.
Definitions	**Exclusions** – Specified conditions or circumstances, listed in this Plan, for which we pay no benefits. Exclusions may apply to services that are medically necessary.		Removed.
Definitions	**Experimental and/or Investigational** – Means a service, supply, or drug that the Plan has classified as experimental and/or investigational for purposes of diagnosing or treating an illness, injury or disease. In order to determine whether a service, supply, or drug is experimental and/or investigational, Samaritan Health Plans will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, or other appropriate publications, and information obtained from the treating provider. Among other factors, Samaritan Health Plans will consider the following in reaching a determination as		Removed.

	to whether a service, supply, or drug is experimental and/or investigational: • If a medication or device, the health intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant peer-reviewed medical literature or by the United States Secretary of Health and Human Services. • The scientific evidence must permit conclusions concerning the effect of the service, supply, or drug on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life. • The service, supply, or drug must improve net health outcome. • The scientific evidence must show that the service, supply, or drug is as beneficial as any established alternatives. • The improvement must be attainable outside the laboratory or clinical research setting. When Samaritan Health Plans receives a claim or request for preauthorization that includes all information necessary to make a decision, you will be informed within 2 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call Member Services Department at (541) 768-4550, toll free1-800-832-4580 or TTY 1-800-735-2900.		
Definitions page 3	**Grievance** – A verbal or written complaint submitted by or on behalf of an enrollee, by an appropriately authorized representative, regarding Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization Claims payment, handling or reimbursement for health care services	**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	Updated language.

	Matters pertaining to the contractual relationship between a member and Samaritan Health Plans	• 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	
Definitions page 3		**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."	Added.
Definitions page 3		**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.	Added.
Definitions page 3	**In-network** – The covered services that you receive from participating providers, also known as contracted, or preferred, providers.	**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.	Updated language.
Definitions page 3	**In-network coinsurance** – The percent (for example, 20%) you pay of the allowed amount for covered services to providers who contract with your Plan. In-network coinsurance usually costs you less than out-of-network coinsurance. See your Benefit Schedule.	**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.	Updated language.
Definitions page 3	**In-network copayment** – A fixed amount (for example, $35) you pay for covered services to providers who contract with your plan. In-network copayments usually are less than out-of-	**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-	Updated language.

	network copayments. See your Benefit Schedule.	network copayments. See your Benefit Schedule.	
Definitions	**In-network provider** – A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network.		Removed.
Definitions page 4	**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, and that are: • in accordance with generally accepted standards of medical practice • clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease • not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors. **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.**	**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	Updated language.

		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.	
Definitions page 4	**Member** – The eligible enrollee or dependent covered under Samaritan Health Plans	**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."	Updated language.
Definitions	**Member Certificate** – Written legal description of the Plan, also called your certificate or policy. This document is your written legal description of the Plan; your 'certificate'.		Removed.
Definitions	**Network** – Facilities, providers and suppliers your health insurer or Plan has contracted with to provide health care services.		Removed.
Definitions	**Non-preferred provider** – A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.		Removed.
Definitions page 4		**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.	Added.
Definitions page 4	**Out-of-network provider** – A provider who doesn't have a contract with your plan to provide services. You'll usually pay more to see an out-of-network provider than an in-network provider.	**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.	Updated language.
Definitions page 5		**Participant** – An employee, or a former employee (such as an employee receiving COBRA continuation coverage) who is enrolled in the plan.	Added.

Definitions	**Participating provider** – A provider that has a contract with us to serve Samaritan Health Plan members.		Removed.
Definitions	**Physician services** – Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.		Removed.
Definitions page 5	**Plan** – Samaritan Health Plans, or "Samaritan", the insurance carrier who issues the Member Certificate(s) as sponsored by the Employer group.	**Plan** – This plan of benefits established and maintained by the employer, the benefits of which are provided under the Group Policy.	Updated language.
Definitions	**Plan Administrator** is defined in ERISA § 3(16). The Plan Administrator is the Employer sponsoring this Plan unless a separate Plan Administrator has been specifically identified and named.		Removed.
Definitions	**Plan Sponsor** – A designated party, usually a company or employer, that sets up a healthcare plan for the benefit of the organization's employees.		Removed.
Definitions	**Plan term** – The group plan becomes effective at 12:01 a.m. on the date written in the vision certificate, 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 as described below.		Removed.
Definitions	**Policy** – Means this Agreement, Group's Contract Application, the Policy, and Member Certificates incorporated herein by reference, and any amendments, exhibits, supplements, addenda, attachments, endorsements, applications, and any information submitted as part of the Application for this Agreement or for membership under this Agreement. A copy of the Group Agreement serves as the Group's services provided by Samaritan Health Plans and responsibilities between Samaritan Health Plans and Group, and when benefit coverage is distributed to a Member, as the Member Certificate.		Removed.
Definitions	**Pre-existing condition** – A provision applicable to an enrollee or late enrollee that excludes coverage for services (this is an exclusion period), charges or cost incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. Samaritan Health Plans does not have an exclusion period or a		Removed.

	pre-existing conditions clause for any services.		
Definitions	**Premium** – The amount that must be paid for your Plan. You and/or your employer pay a portion every month as agreed upon between Samaritan Health Plans and your Plan Administrator.		Removed.
Definitions	**Professional services** – Services of a professional medical provider for medically appropriate diagnosis or treatment of illness or injury, and for preventive care services.		Removed.
Definitions	**Professional provider** – A licensed optometrist or other provider acting within the scope of their license. Samaritan Health Plans does not discriminate against provider acting within the scope of their own licensure or certification.		Removed.
Definitions	**Provider –** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.		Removed.
Definitions page 5		**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.	Added.
Definitions page 5	**Service area** – The State of Oregon.	**Service area** – Samaritan Health Plan options are available for purchase statewide in the State of Oregon for Oregon domiciled businesses.	Updated language.

Definitions page 5	**Spouse** – To whom you are married and/or your domestic partnership.	**Spouse** – To whom you are married.	Updated language.
Definitions page 5		**Supplies** – Consumable goods to support health care services.	Added.
Definitions	**Urgent care services** – Services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than true medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.		Removed.
Definitions	**Usual, Customary and Reasonable (UCR) charges** – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service, as determined by Samaritan Health Plans. The UCR will be determined by Samaritan Health Plans by utilizing appropriate data, such as that collected by the Centers for Medicare and Medicaid Services, contracted vendors, and other databases. The UCR may be used to determine the allowed amount for a given procedure, supply, or service. Samaritan Health Plans members may be responsible for UCR charges if services are provided by out-of-network providers.		Removed.
Definitions page 5		**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.	Added.
Definitions	**When coverage begins** – • The first of the month after we have received your completed enrollment materials from the Employer • From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Plan **Coverage ends at the end of the month when –** • You have not paid your premiums • You otherwise fail to satisfy the eligibility requirements of Samaritan Health Plans and your employer • Your employer group has taken residence out of state		Removed.

Definitions page 5	**You or your** – The person enrolled for coverage in the Plan, including any dependents.	**You or your** – The person enrolled for coverage in the plan. Where the context so implies, it also includes any of your enrolled dependents.	Updated language.
Provider Directory page 7		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.	Added.
Employees page 9	Your employer decides the minimum number of hours employees must work each week to be eligible for benefits. Your employer can also require new employees to satisfy a probationary waiting period before they are eligible for benefits. All employees who meet their employer's eligibility requirements are eligible for coverage. Eligibility is not based on any health status-related factors.	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 these requirements are eligible to enroll in the plan. Eligibility is not based on any health status-related factors.	Updated language.
Family Members page 9	While you are insured under this plan, the following family members are also eligible for coverage: • Your legal spouse or qualified domestic partner. • Your, your spouse's, or your domestic partner's dependent children until your dependent attains age 26, regardless of the child's place of residence, marital status, or financial dependence on you. • Your siblings, nieces, nephews, or grandchildren until your dependent attains age 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 domestic partner's dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability.	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: o a biological child of you or your spouse; o an adopted child of you or your spouse; o a child actually placed with you while adoption proceedings are pending; o a child for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO); o a child for whom you are legal guardian; and o a child of a qualified domestic partner. • Your siblings, nieces, nephews, or grandchildren under the age of 26	Updated language.

	○ Samaritan Health Plans requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage. No family or household members other than those listed above are eligible to enroll under your coverage. • Any dependent children until they reach the age of 26, and for purposes of coverage under the Plan, the term "child" includes: ○ 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 ○ a child of a qualified domestic partner of an employee (see applicable IRS information below) 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. Dependent parents, foster children, and any other relative not described above are not eligible for coverage under the Plan.	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.	
When You First Become Eligible page 10	The initial enrollment period is the 30 day period beginning on the date a person is first eligible for enrollment in this Plan. Everyone who becomes eligible for coverage has an initial enrollment period. When you satisfy your employer's probationary waiting period at the hours required for eligibility and become eligible to enroll in this Plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you may have to wait to enroll at the next open enrollment period. 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	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	Updated language.

	enrolling family members. Return the application to your employer, and your employer will send it to Samaritan Health Plans by the end of the 30 day period. Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your employer's probationary waiting period. Check with your employer for their probationary waiting period. Coverage will only begin if we receive your enrollment application and premium with your employer's premium payment for that month.	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.	
Newly Hired/Eligible Employees and Their Dependents	Newly hired employees and employees that begin working the hours required for eligibility may enroll themselves and their eligible dependents after satisfying the initial enrollment period. The newly eligible employee must complete and submit to the employer an enrollment form within 30 days of becoming eligible for enrollment. Coverage is effective on the first of the month following completion of the waiting period at the hours required for eligibility.		Removed.
Open Enrollment page 10		The 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.	Added.
Mid-Year Special Enrollment – Newborns page 10	Your, your spouse's, or your domestic partner's newborn baby is eligible for enrollment under this plan during the 30 day initial enrollment 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 can be required to submit a copy of the newborn's birth certificate to complete enrollment. If additional premium 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 premium. Premium is charged from the date of birth and prorated for the first month.	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.	Updated language.

	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.	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 page 10	When a child is placed in your home for adoption, the child is eligible for enrollment under this plan 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 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 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.	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.	Updated language.
Mid-Year Special Enrollment – Family Members Acquired by Marriage page 11	If you marry, you can add your new spouse and any newly eligible dependent children to your coverage during the 30 day initial enrollment period after 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 marriage. You can be required to submit a copy of your marriage certificate to complete enrollment.	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.	Updated language.
Mid-Year Special Enrollment – Family Members Acquired by	Your qualified domestic partner can enroll by submitting an enrollment application at the time of your initial enrollment or within 30 days of the partnership first becoming eligible	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	Updated language.

Domestic Partnership page 11	according to the criteria stated under Your eligibility. All other domestic partner applications will be subject to late enrollment provisions. The Oregon Family Fairness Act recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." Requirements beyond this are not allowed for same sex domestic partners. Any time that coverage is extended to a spouse it must also extend to a domestic partner.	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 page 11	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, registered or otherwise • Under age 26 • Expected to live in your household for at least a year, unless otherwise ordered by court We 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.	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.	Updated language.
Waiver of Coverage	You may waive coverage under the Plan for yourself. You may also waive coverage for any of your eligible dependents. If you waive coverage for yourself, your dependents are not eligible for coverage. To waive coverage, you must file *a Declination of Coverage* form with your employer or Plan Administrator specifying the reason for the waiver. The form must list by name each of the dependents for which you waive coverage.		Removed.
Subsequent Enrollment	If you do not enroll yourself and/or your eligible dependents within 30 days of first becoming eligible, you may be considered a "late enrollee." If so, you must wait until the next open enrollment period to enroll.		Removed.
Replacement of Prior Policy	**If this group policy replaces an existing policy or contract of another**		Removed.

	insurance company, the following applies: • When a member is hospitalized on the date this policy becomes effective, Samaritan Health Plans will consider charges with a date of service coinciding with the member's effective date. Any benefits provided are subject to any prior carrier's obligations under state law or contract. • In any situation where a determination of the prior plan's benefit is required, the member is responsible for furnishing evidence of the terms of the prior plan, and of claim payments made by the prior plan.		
Other Special Enrollment Events page 12	You and your family members can enroll in this Plan later if you qualify under Rule #1, Rule #2, or Rule #3 below. If the agreement between Samaritan Health Plans and your employer requires all eligible employees to participate in this Plan, you must enroll during your initial enrollment period. However, your family members can decline coverage, and they can enroll in the Plan later if they qualify under Rule #1, Rule #2, or Rule #3 below. To find out if your employer's plan allows employees to decline coverage, ask your Plan Administrator.	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.	Updated language.
Special Enrollment – Loss of Eligibility for Other Coverage page 12	If you declined enrollment for yourself or your family members because of other coverage, you or your family members can enroll in the plan later if the other coverage ends involuntarily. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse or	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	Updated language.

	domestic partner, divorce, or legal separation. To do so, you must request enrollment within 30 days after the other 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.	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 page 13	If you or your dependents are terminated from Medicaid or a State Children's Hospital Insurance Program (CHIP), or become eligible for a premium assistance subsidy under Medicaid or CHIP, you can enroll yourself and/or your dependents on the Plan at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.	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.	Updated language.
Qualified Medical Child Support Orders (QMCSO) page 13	This Plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for benefit coverage for the child of a plan member. If a court or state agency orders coverage for your spouse, domestic partner or child, they can enroll in this plan within a 30 day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after Samaritan Health Plans receives the enrollment application. You can be required to submit a copy of the QMCSO to complete enrollment. Samaritan Health Plans will extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA. Samaritan Health Plans has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from our Member Services Department.	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	Updated language.

		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.	
Late Enrollment	If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the next open enrollment. A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who: • Did not enroll during the 30 day initial enrollment period • Enrolled during the initial enrollment period but discontinued coverage later A late enrollee can enroll by submitting an enrollment application to your employer during an open enrollment period designated by your employer, just prior to the Plan's anniversary date. When you or your dependents enroll during the open enrollment period, plan coverage begins on the Plan's anniversary date.		Removed.
Waiting Periods	Samaritan Health Plans does not have waiting periods.		Removed.
Termination of Coverage page 13	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 on the last day of the last month 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 Continuation of Coverage for more information. Any termination of coverage will be based on your date of termination, in which case any premiums will be retroactively adjusted and refunded. If your employment with the Employer ends, coverage for you and your covered dependents will ordinarily stop on the last day of the month your employment ends. However, you and your covered dependents may then be able to extend coverage on a self-pay basis (unless your employment was terminated for reasons of gross misconduct). See Continuation Coverage for details on the extended coverage. You can voluntarily discontinue coverage for your enrolled family members at any time by completing an Enrollment Change/Waiver form and	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.	Updated language.

	submitting it to your employer. Keep in mind that once coverage is discontinued, your family members may not be able to enroll until the next enrollment period.		
Change in Employee Status	If you cease to be a regular, full-time employee (i.e., you cease to be assigned to a position in which you are regularly scheduled to work at least 17.5 hours a week), then the coverage for you and your dependents will ordinarily end on the last day of the month in which your transfer of position occurs. However, you will need to work with your employer and Plan Administrator to determine coverage changes.		Removed.
Divorced Spouses or Legal Separation page 13	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 Plan Administrator of the divorce or separation, and continuation coverage can be available for your spouse. If there are special child custody circumstances, please contact the Plan's Member Services Department. See Continuation of Coverage for more information.	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.	Updated language.
Dependent Children page 14	When your enrolled child no longer qualifies as a dependent, coverage will end the last day in the month dependent attains the age of 26. See Your eligibility for information on when your dependent child is eligible beyond age 25. See Continuation of Coverage and Special enrollment periods where you can find more information on other coverage options for those who no longer qualify for coverage.	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.	Updated language.
Dissolution of Domestic Partnership page 14	If you dissolve your 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 and continuation coverage can be available for your domestic partner and their covered children. See Continuation Coverage for more information.	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.	Updated language.
If Your Children Are No Longer Eligible	Coverage normally ends on the last day of the month when your children are no longer eligible because they have aged over 26. Your children may extend their coverage for up to 36 months on a self-pay basis. Refer to the Continuation		Removed.

	coverage section for details on the extended coverage.		
Certificates of Creditable Coverage	For questions or requests regarding certificates of creditable coverage, you are welcome to contact our Member Services Department at (541) 768-4550 or (800) 832-4580.		Removed.
Disenrollment	Your employer determines enrollment and disenrollment of participants and is responsible for notifying you of your disenrollment. You may be disenrolled from Samaritan Health Plans for various reasons such as: • Your personal situation may change and you may no longer be eligible for this program • You did not pay your premium on time and are no longer eligible for the Plan. In this case, you have a 10 day grace period after the premium due date in which to pay your past due premium. • You die. Termination of coverage will be your date of death, in which case any premiums will be retroactively adjusted and refunded. Samaritan Health Plans will provide your group policyholder with a termination notice that includes your rights and continuation options within 10 days of the effective date of the termination, when your coverage is not replaced by another group policy.		Removed.
Federal and State Continuation Coverage page 15	Federal law requires that most employers sponsoring group health plans offer employees and their family members the opportunity to continue their group health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. If you are the spouse of an employee that works for an employer that has at least 20 employees on a typical business day during the preceding calendar year, you may be eligible for a specific type of state continuation coverage. You must be 55 years of age or older, and be separated, divorced, or your spouse (employee) dies, for you and your dependents to be eligible to continue your coverage. Please contact your employer for information on how to continue coverage under this state law. If you are covered by Federal (COBRA) or State continuation coverage, and your employer changed size, contact your employer to verify your continuation coverage benefits.	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.	Updated language.

	Continuation of coverage is not available to a covered person or qualified beneficiary who is eligible for: (a) Medicare; or (b) The same coverage under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.		
Federal COBRA Continuation page 15	If you work for an employer that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year, your employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please contact your employer for information about how to continue coverage under COBRA. Domestic partners are not recognized as qualified beneficiaries under federal COBRA continuation laws and thus cannot continue this policy's coverage under COBRA. Their covered children as qualified beneficiaries can continue this policy's coverage if all COBRA requirements are met. Oregon State continuation Under this plan, you can have continuation coverage rights under Oregon state law.	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. [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.	Updated language.

		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 Employee's termination of employment hours Employee's divorce or legal separation Employee's eligibility for Medicare bene loss of coverage Employee's death Child no longer qualifies as a dependent [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 page 18	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 or domestic partner and dependent children can also continue coverage under this plan if you divorce, dissolve your domestic partnership, 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	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.	Updated language.

	restrictions also apply to anyone electing Oregon continuation coverage: To qualify for continuation, you must have been covered under a group policy for at least three months before the date of the qualifying event. If your employer recently switched to this 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 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 this Plan is discontinued by your employer or otherwise terminated, you will no longer qualify for continuation through Samaritan Health Plans. 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. When continuation coverage ends, you can be eligible to purchase an individual continuation policy.	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	

	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 group health plan will also apply to everyone enrolled in continuation coverage. We can provide you uninterrupted coverage when the existing policy is replaced.	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 page 20	If your employer had 20 or more employees on a typical business day in the previous calendar year, your spouse and dependents that lose coverage due to a divorce, legal separation, or your death, can be eligible to continue their coverage. Please contact your employer for information about how to continue coverage under this Oregon law.	Subject to the general provision of the plan, if you die, become divorced or legally 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 [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	Updated language.

		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.]	
Continuation After Injury or Illness Covered by Workers' Compensation page 21		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.	Added.
Labor Unions page 21	If you are a union member, you have certain continuation rights in the event of a labor strike or lockout. Your Plan Sponsor is responsible for collecting your premium and can answer questions about coverage during the strike.	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.	Updated language.
Employer Contribution	Samaritan Health Plans cannot deny an employer's application for coverage under this plan based on participation or contribution requirements but can require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period. For every group plan, the Plan Sponsor that chooses to enforce participation, contribution or eligibility requirements must: • Specify in the Plan all of participation, contribution, and eligibility requirements that have been agreed upon by the carrier and the group • Apply the participation and eligibility requirements uniformly to all categories of eligible members and their dependents		Removed.
Plan Benefits page 22	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,	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,	Updated language.

	optician, or optometrist. However, for eye examinations, there is a difference in reimbursement for participating vision providers and non-participating vision providers. **Deductible** There is **no deductible** for covered vision services or supplies and the benefits are paid, up to the limits listed in your Benefit Schedule, for services at participating vision providers. These vision care benefits are provided on a calendar year basis. **Small Group Plans** As it applies to small group plans, the medical embedded (pediatric) vision coverage is primary to this Vision plan that is purchased separately. Medical deductibles do not need to be met prior to obtaining this Vision coverage, however IF there is a deductible required for the medical plan with embedded (pediatric) vision coverage, the deductible may need to be met first.	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 page 22	**Eye Examinations:** One comprehensive eye exam (including eye refraction 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 • Lenses are covered when eyeglasses are first acquired or when required by a change in prescription	**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	Updated language.
Limitations and Exclusions page 22	The vision care benefit will only pay for the items listed above up to the allowable amount per individual and per calendar year. **Exclusions** The following are not covered benefits under this Plan: • Visual fields testing • Contact lens or eyeglass fitting fees • Orthoptics or vision training • Lenticular lenses	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	Updated language.

	• Contact lenses, except as shown in the Benefit Schedule • Subnormal vision aids • Aniseikonic lenses • High index lenses other than polycarbonate • Lens extras, such as photochromic lenses and glare coatings • Hardware repairs • Nonprescription or Plano lenses • More than the allowance for a standard prescription • Extra charges for fashion eyewear features such as blended bifocals, flash coated, glass lenses, oversize lenses, or more than the standard cost for frames • Medical or surgical treatment of the eyes • Services and supplies that are payable under a workers' compensation or occupational disease law • Any expense which is in excess of the maximum plan allowance • Any eye examination required as a condition of employment • Replacement of lost, stolen, or broken lenses • Duplication or spare eyeglasses, lenses or frames • Any expense paid in whole or in part by any other provision by the Policyholder • Experimental or investigational vision services are excluded under the same standards as the medical benefits	• 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 occupation 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.	
Explanation of Benefits (EOB)	We will report to you the action we take on a claim on a form called an Explanation of Benefits (EOB). If we deny all or part of a claim, the reason for our action will be stated on the EOB. The EOB will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your claim; when benefits are available; the cost of a service is incurred on the day the service is rendered and the cost of a supply is incurred on the day the supply is delivered to the patient. There are two exceptions to this rule. One is when you are in the hospital on the day coverage ends. In this case, we will continue to pay toward eligible charges for the hospitalization until discharge from the hospital or until your benefits have been exhausted, whichever comes first.		Removed language and renamed section to 'Member Claim Reimbursements'.

Member Claim Reimbursements page 24	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 policy 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.	**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.	Renamed section.
Claims Involving Concurrent Care Decisions	If an ongoing course of treatment for you has been approved by Samaritan Health Plans and it then determines through its medical cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Samaritan Health Plans will then notify you of its reconsideration decision within 24 hours after your request is received.		Removed.
When the Hospital Bills You	You can be billed for inpatient care you receive in an out-of-network hospital, and for outpatient care you receive in any hospital outside our service area that can be paid by the provisions of this plan. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following: • The name of the covered person who was treated • Your name and your group and identification numbers • A description of the symptoms that were observed or a diagnosis • A description of the services and the dates on which they were given If you have already paid for the services or supplies, please note that fact boldly on the billing and include a receipt. Reimbursement forms are available online or by calling our Member Services Department at 541-768-4550, toll-free at 1-800-832-4580; TTY 1-800-735-2900; Monday through Friday 8 a.m. to 5 p.m. The same procedure should be followed with bills for hospital or physician care you received outside the United States, for Emergency services ONLY.		Removed.

	Reimbursement will be made at the current rate of exchange at the time the claims are processed.		
Claim Forms	The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.		Removed.
Physicians' Charges	Your physician can bill charges directly to us. Payment will be made directly to the provider. If your physician does not bill us directly, you can send physician bills to us yourself. Be sure the physician uses his or her billing form and includes on the bill: • the patient's name and the group and identification number • the date treatment was given • the diagnosis • an itemized description of the services given and the charges for them If you have already paid the services and supplies, please note that fact boldly on the form and include a receipt. If the treatment is for an accidental injury, include a statement explaining the dates, time, place, and circumstances of the accident when you send us the physician's bill.		Removed.
Physician Reimbursement	You are entitled to ask if Samaritan Health Plans has special financial arrangements with our physicians that can affect the use of referrals and other services. To get this information, call our Member Services Department and request information about our physician payment arrangements.		Removed.
Filing a Lawsuit	Any civil action must be filed within the timeframe mandated by ORS 743.441.		Removed.
Other Health Care Charges	As we explained previously in the description of benefits, the Plan will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. You can also send them to us at regular intervals, for example, once a month. Again, if you have already paid for the services and supplies, please note that fact boldly on the form and include a copy of your receipt.		Removed.

Prescription Medication Rebates	Samaritan Health Plans participates in arrangements with medication manufacturer's, which allows us to receive rebates based on volume of certain prescription medication purchased on behalf of covered individuals Any rebates that we receive from medication manufacturers will be used to help minimize future covered health care expenses for individual members and the health plan.		Removed.
Appliances	By this term, we mean things such as artificial limbs, crutches, and wheelchairs. Bills for any of these items should include a complete description of the appliance and the reason it is needed. If your doctor wrote a prescription for the appliance, this should also be included with your claim. Always include your group and identification numbers and the patient's name.		Removed.
Ambulance Service	Bills for ambulance service must show where the patient was picked up and where he or she was taken. They should also show the date of service, the patient's name, group, and member identification numbers. We will send our payment for covered expenses directly to the ambulance service provider.		Removed.
Time of Payment of Claims	Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.		Removed.
Timely Submission of Claims	Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon Division of Financial Regulation administrative rule setting standards for prompt payment. **Please send all claims to:** Samaritan Health Plans P.O. Box 887 Corvallis, OR 97339		Removed.
Motor Vehicle Coverage	In addition to liability insurance, most motor vehicle insurance policies are required by law to provide primary medical payments insurance and uncovered motorist insurance. Many motor vehicle policies also provide underinsurance coverage. Benefits for		Removed.

	health care expenses are excluded under this policy to the extent that you are able to or are entitled to recover from any type of motor vehicle insurance coverage. **Here are Some Rules, Which Apply with Regard to Motor Vehicle Insurance Coverage:** • If a claim for health care expenses arising out of a motor vehicle accident is filed with us and motor vehicle insurance has not yet paid, we may advance benefits as long as you agree in writing: o to give information about any motor vehicle insurance coverage which can be available to you or your covered dependent o to hold the proceeds of any recovery from motor vehicle insurance in trust for us and reimburse us as provided in the following paragraphs • If we have paid benefits before motor vehicle insurance has paid, we are entitled to have the amount of the benefit we have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of you, is held in trust for us. This is true whether such recovery or payment is from primary medical payments coverage, uninsured motorist coverage or underinsured motorist coverage. • If you or your covered dependent incurs health care expenses for treatment of an illness or injury arising out of a motor vehicle accident after receiving a recovery from uninsured or underinsured motor vehicle coverage, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceed the Net Recovery Amount (as defined in the "Third Party Liability" provision). • You or your covered dependent who was involved in a motor vehicle accident can have rights both under motor vehicle insurance coverage and against a third party who can be responsible for the accident. In that case, both this provision and the "Third Party Liability" provision apply.		

Third Party Liability and Right of Subrogation	This provision applies when you incur health care expenses in connection with an illness or injury for which one or more third parties can be responsible. In that situation, benefits for such expenses are excluded under this policy to the extent you receive a recovery from or on behalf of the responsible third party. **Here are Some Rules, Which Apply in these Third-Party Liability Situations:** • If a claim for health care cost is filed with us and you have not yet received recovery from the responsible person, we can advance benefits for covered expenses if you agree to hold, or directs your attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the illness or injury. • If we pay benefits, we will be entitled to have the amount of the benefits we have paid separated from the proceeds of any recovery you receive from or on behalf of the third party and held in trust for payment to us. • We are entitled to the amount of benefits we have paid in connection with the illness or injury, regardless of whether you or your covered dependent has been made whole, from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you or your covered dependent, the third party's insurer, or any other insurance recovery. This is so regardless of whether: the third party or the third party's insurer admits liability; the health care expenses are itemized or expressly excluded in the third-party recovery; or the recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the policy. The amount to be in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties. • If you make a recovery and fail to hold in trust for us the amount of paid benefits and to pay us that		Removed.

	amount as required by this Third Party Liability (TPL) provision, we can limit future treatment or future medical benefits for any care up to the amount of benefits we paid for the illness or injury caused by the third party. Not all TPL claims will go to subrogation. Samaritan Health Plans follows rules on Third Party Liability and subrogation to the full intent of the law. • We expect full reimbursement before any amounts are deducted from the policy, proceeds, award, judgement, settlement, or other arrangement. This obligation to reimburse the Plan shall be equally binding upon the Covered Person regardless of whether or not the third party or its insurer has admitted liability or the medical charges are itemized in the third party payment. • If you or your dependent incurs health care expenses for treatment of the illness or injury after recovery, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount. **The Term "Net Recovery Amount" is Calculated as Follows:** the amount of recovery; plus the amount you recovered from any other source such as other insurance as a result of the illness or injury; *Minus* the difference between the total amount of third-party related health expenses incurred prior to the recovery and the benefits we paid before the recovery toward such cost; *Minus* the amount you reimbursed to us out of the recovery for benefits we paid before the recovery; *Minus* the total expenses paid by you when getting the recovery such as reasonable attorney fees and court expenses; shall equal the "net recovery amount."		

Workers' Compensation	This provision applies if you have made or is entitled to make a claim for workers' compensation. Benefits for treatment of an illness or injury arising out of or in the course of employment or self-employment for wages or profit are subject to review for proper adjudication. Services can be subject to additional recovery. The only exception would be if you are exempt from state or federal workers' compensation law.		Removed.
Medicare page 25	In certain situations, this Plan is primary to Medicare. When someone has Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are: • When you or your spouse is age 65 or over and by law Medicare is secondary to your employer group health plan. • When you incur eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and • When you are entitled to benefits under section 226(b) of the social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan. In all other instances, we will not pay benefits toward any part of a covered cost to the extent the covered cost is actually paid under Medicare Part A or B had you or your covered dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare, we will not pay any part of expenses a Medicare-eligible covered member incurs from providers who have opted out of Medicare participation.	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.	Updated language.
This Plan	This Plan means, as used in this COB section, the part of this contract to which this COB section applies and which can be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from this Plan. A contract can apply one COB provision to certain benefits, such as medical benefits, coordinating only with similar benefits, and can apply another COB provision to coordinate other benefits. The order of benefit determination rules listed on page 55 determine whether this Plan is a Primary plan or Secondary		Removed.

	plan when a member has health care coverage under more than one plan.		
Coordination page 26	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 .	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.	Renamed and updated language.
Allowable Expenses page 26	Allowable charges means a health care cost, including deductibles, coinsurance and copayment, 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 charge and a benefit paid. A charge that is not covered by any Plan covering a Member is not an Allowable charge. 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 charge. **The Following are Examples of Expenses that are NOT Allowable Charges:** • The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable charge, unless one of the plans provides coverage for private hospital room expenses. • If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable charge. • If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable charge. • If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that	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.	Updated language.

	provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable charge for all plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable charge used by the Secondary plan to determine its benefits. • The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable charge. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and in-network provider arrangements.		
Workers' Compensation	We are required to provide coverage for claims for covered services denied or not yet adjudicated by the workers' compensation carrier.		Removed.
Member Grievance and Appeals Review page 31	**Filing a Grievance** **Adverse Benefit Determination** means**:** • Denial of eligibility for or termination of enrollment in a 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 • Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care **Grievance** means a verbal or written complaint regarding: • Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the	**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	Updated language.

	decision of the Plan through a prior authorization • Claims payment, handling or reimbursement for health care services • Matters pertaining to the contractual relationship between the member and the plan You or your Authorized Representative can file a 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 a level 1 Appeal** **Authorized Representative:** An individual who by law or by the consent of a person can act on behalf of the person. An 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 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 case. You or your Authorized Representative will receive a written decision within 30 days of our receiving your appeal request. **Please Note:** If you, your Authorized Representative or your treating provider believes that the request to appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, your appeal will be processed in an expedited manner. For urgent appeals, your treating provider can act as your Authorized Representative.	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.	

	If your request for appeal meets the definition of urgent, you or your Authorized Representative can request a simultaneous expedited External Review. For more information, please refer to Expedited Appeal Process. **External Review** External Review decisions are made by Independent Review Organizations (IRO) that is not associated with Samaritan Health Plans. Your appeal will be randomly assigned to an IRO by the Oregon Division of Financial Regulation. Your appeal can qualify for an External Review (at no cost to you) if: • the Plan does not adhere to the rules and guidelines of the process defined for the internal review • Internal appeal level 1 has been completed; and, the reason for the level 1 adverse decision was: o based on medical necessity o for treatment determined to be experimental or investigational o an active course of treatment for the purpose of continuity of care (no interruption of an active course of treatment) • you and the Plan have mutually agreed to waive the internal appeals requirement We must receive your written request for an External Review within 180 days of the Level 1 adverse decision. **Please Note:** When you send a request for External Review, you or your Authorized Representative must submit a signed waiver granting the IRO access to your medical records pertaining to the adverse decision. You can request the waiver form from the Plan. If your request meets the definition of urgent as defined by law, you or your Authorized Representative can request an expedited External Review. For more information, please refer to Expedited Appeal Process. To apply for an External Review you must send your written request or the Appeal Request Form to us: **By mail:** Samaritan Health Plans – Appeals Team P.O. Box 1310 Corvallis, Oregon 97339 **By fax:** 541-768-9765		

	By email: SHPOAppealsTeam@samhealth.org Once the OID has notified the Plan of the assigned IRO, we will submit your External Review request to the IRO within 5 business days. When you are notified by the IRO that your request for External Review has been received, you will have 5 business days to submit additional information about your appeal. The IRO will return a written decision to you or your Authorized Representative and to the Plan within the following timeframes: Expedited External Review – 3 days after receipt of the request Standard External Review - 30 days after receipt of the request IRO decisions are final and we are bound by their decisions. If you want more information regarding External Review, please contact our Member Services Department at 541-768-4550; toll-free at 800-832-4580 or TTY 1-800-735-2900. **Expedited Appeal Process** If you believe your appeal is urgent, you, your Authorized Representative or your treating provider, can request an Expedited appeal. If the appeal request meets the definition of urgent under the law; which means, a decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, the appeal will be processed in an expedited manner (within 3 business days of our receiving the appeal request). If the appeal does not meet the definition of urgent, you will be notified immediately and the appeal will then be processed within the standard timeframe. **The Expedited Appeal Request Must:** • be filed verbally or in writing within 180 days after you receive notice of the initial written pre-service denial • state the reason for the appeal request • state the reason an expedited decision is needed • include supporting documentation necessary to make a decision • When applicable, if you are simultaneously requesting an		

	expedited External Review in addition to an expedited internal review, a signed waiver granting the IRO access to your medical records pertaining to the adverse decision must be included. • The internal Expedited review decision will be determined by a healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative and your treating provider as soon as possible, but no later than 3 days of our receiving the appeal. A written notice will be mailed within one working day following the verbal notification. If you have requested a simultaneous expedited External Review, the Plan will also forward your appeal to the IRO. Once the IRO has made a decision, Samaritan Health Plans is obligated to follow and honor the decision that was made by the IRO, regardless of the decision or opinions made by Samaritan Health Plans. If Samaritan Health Plans does not honor the decision made by the IRO, you or your authorized representative has the right to sue. **To Apply for an Expedited Review by an IRO:** Send your written request, or the Appeal Request Form, to: **By mail:** Samaritan Health Plans – Appeals Team P.O. Box 1310 Corvallis, Oregon 97339 **By fax:** 541-768-9765 **By email:** SHPOAppealsTeam@samhealth.org Or call our Member Services Department: (541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900 Appeal Timeframes Samaritan Health Plans has the following timeframes for making internal review decisions on appeals: • 3 business days for urgent appeals • 30 days for pre service appeals • 30 days for post service appeals To obtain an Appeal Request Form or a waiver granting IRO access to your medical records visit www.samhealthplans.org or call our Member Services Department at (541)		

	768-4550, toll free 800-832-4580 or TTY 1-800-735-2900. Your Appeal Rights You have the right to: • File a grievance about and/or appeal any decision we make regarding availability, delivery or quality of health care services, or an adverse determination based on the decision of the Plan through a prior authorization, claims payment, handling or reimbursement for healthcare services or matters pertaining to the contractual relationship between the member and the Plan • Appoint someone to act as your Authorized Representative when filing a grievance or appeal, such as a relative, friend, treating physician, advocate, attorney, or someone else who has been legally appointed • Contact us when you: o Do not understand the reason for the denial o Do not understand why the health care service or treatment was not fully covered o Do not understand why a request for coverage of a health care service or treatment was not approved o Cannot find the applicable provision in your policy o Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision • Request within 180 days of the denial, or other action giving rise to the grievance or appeal, a 1st level of Internal Appeal • Continued coverage of an approved and ongoing course of treatment pending the conclusion of the internal appeal process • A full and fair internal review of your appeal by healthcare professionals associated with us, but who were not involved in the action being appealed • Provide us with additional information that relates to your appeal • Appear in person to talk about your internal levels of appeal		

	• An internal review decision within 30 days for appeals and 3 days for an expedited appeal • Request a copy of the information in your appeal (free of charge) regardless if it was used to make the decision • File an External Review (at no cost to you) within 180 days if applicable • An External Review decision within 30 days of the IRO receiving your standard request and 3 days for an expedited request • Send additional information, in writing, directly to the IRO, no later than 5 business days after the appointment of the IRO or 24 hours in the case of an expedited review • An Expedited Review if you, your Authorized Representative or your treating provider believes that waiting the standard 30 day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed • A simultaneous Expedited Internal and External Review, if applicable • Information about our grievance and appeal processes. Contact our Member Services Department at 541-768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900; or you can contact us by the following: **By mail:** Samaritan Health Plans – Appeals Team P.O. Box 1310 Corvallis, Oregon 97339 **By fax:** 541-768-9765 **By email:** SHPOAppealsTeam@samhealth.org • To pursue civil action in accordance to 502(a) of the Employee Retirement Income Security Act of 1974 after you have exhausted appeal on an adverse benefit determination • The insurer is bound to follow the decision of the IRO, and can be penalized by DCBS if it fails to do so • The enrollee is financially responsible for benefits paid to or on behalf of an enrollee pursuant to ORS 743.804(2)(g) if the insurer's adverse benefit determination is upheld on appeal		

	• Other dispute options, such as mediation. One way to find options that can be available is to contact your state Insurance Commissioner. You have the right to file a complaint or seek other assistance from 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@state.or.us **By writing:** Oregon Division of Financial Regulation Consumer Advocacy Unit at: PO Box 14480; Salem, OR 97309-0405 **Consumer Advocacy website:** http://dfr.oregon.gov/Pages/index/aspx You can, at any time, request a copy of these materials. If requested, we will send you a copy of those materials within 30 days of your request. • Annual summary of grievance and appeals • Annual summary of utilization review policies • Annual summary of quality assessment activities • The results of all publically available accreditation surveys • An annual summary of our health promotion and disease prevention activities • An annual summary of scope of network and accessibility of services		
HIPAA Privacy Notice page 32	Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information (PHI). A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager. This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has	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.	Updated language.

	required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. 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. This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have questions about the privacy of your 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.	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.	
Inmates page 35	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 For services provided on or after 1/1/2015, we will not deny reimbursement for any service or supply covered by the plan or cancel the coverage of an insured 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	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	Updated language.

	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 plan		
Written Authorization page 36	For any other use or disclosure of your medical information, SHPO will ask for your written permission before using or disclosing your information. You may cancel this permission at any time in writing, but SHPO cannot take back any uses or disclosures already made with your permission. There are many programs that have their own laws for the use and disclosure of information about you, which we too must follow. For example, you generally must give your written permission for SHPO to use and disclose your mental health and chemical dependency treatment records.	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.	Updated language.
Protection of Genetic Information page 36		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.	Added.
Notification of Breach of Unsecured Health Information page 36		You will be promptly notified if SHPO or a business associate discovers a breach of unsecured health information that affects you.	Added.
Complaints page 38	If you believe your privacy rights have been violated, you may file a complaint with Samaritan Health Plan Operations by plan. Please refer to your Member Handbook or Evidence of Coverage for contact information. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints to SHPO must be submitted in writing to SHPO at the address below. You will not be penalized for filing a complaint.	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.	Updated language.
Your Responsibilities as a Member page 39	• A responsibility to supply information (to the extent possible) that the organization and its	• A responsibility to supply information (to the extent possible) that the organization and its	Updated language.

	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 development 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. • You are responsible for making sure services are prior authorized when required by this Plan before receiving medical care.	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.	
What are your pre-authorization and utilization review criteria?	Pre-authorization, also known as prior authorization is the process we use to determine the medical necessity of a service before it is rendered. Contact our Member Services Department at the phone number on the back of your identification card and also review the Prior Authorization list. Many types of treatment can be available for certain conditions. The pre-authorization process helps the provider work together with you, other providers, and us to determine the treatment that best meets your medical needs and to avoid duplication of services. This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, pre-authorization is your assurance that medical services will not be denied because they are not medically necessary. Utilization review is a process in which we examine services you receive to ensure that they are medically necessary—with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of medically necessary under Definitions. Let us know if you would like a written summary of information that we can consider in our utilization review of a particular condition or disease. Simply call the Member Services Department phone number on the back of your identification card.		Removed.

Governing Law page 43	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. 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.	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.	Updated language.
Compliance with State and Federal Mandates page 43	To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the Policy, including Patient Protection and Affordable Care Act (PPACA, the Employee Retirement Income Security Act of 1974 (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Civil rights and employment laws including Titles VI and VII of the Civil Rights Act of 1964, sections 503 and 504 of the Rehabilitation Act of 19767; The Americans with Disabilities Act of 1990; Executive Order 11246; the Age Discrimination in Employment Act of 196; and the Age Discrimination Act of 1975; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), and the Women's Health and Cancer Rights Act of 1998 (WHCRA). These laws have been amended from time to time. In the event of any conflict between these provisions and the current provisions of the law, the current provisions of the law shall govern.	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.	Updated language.
Other Authorities and Responsibilities page 43	Samaritan Health Plans is not the named fiduciary 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 Group or Member eligibility determinations. Samaritan Health Plans may make factual determinations relating to benefits provided under the Plan. SHP 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. You cannot assign any benefit or money due under this Plan to any other person, medical service or supply provider, corporation, or any other organization.	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	Updated language.

	Any assignment by you will be void and of no effect. For purposes of this provision, an "assignment" refers to the transfer of your rights to the benefits described in this Certificate and the accompany Group Plan Agreement, to any other person, corporation, or other organization or entity.	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.	
ERISA	If your plan is governed by ERISA, then ERISA rules apply to your plan. If your group is not subject to ERISA, disregard all ERISA references.		Removed.
Changing this Certificate page 43	This Certificate explains the benefits available to you under the group insurance 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. This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer 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.	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. TNo 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.	Updated language.
Group Contract Renewal and Termination page 44	The Contract will renew automatically from year to year unless terminated as otherwise provided in the Contract. Termination of the member under the Contract for any reason will completely end all obligations of the Company to provide the member with Benefits after the date of termination, except where required by Oregon Revised Statutes. Samaritan Health Plans must receive written notice of termination from the Group, provided that Samaritan Health Plans receives the notice at least 30 days in advance of the proposed termination date. The employer group	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	Updated language.

	must provide in writing whether Samaritan Health Plans is being replaced by another group policy. The employer group shall continue to be liable for Samaritan Health Plans premiums for all members enrolled in Samaritan Health Plans through the employer group through the end of the first full month requested and agreed upon termination date.	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 page 44		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	Added
Reinstatement	If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for		Removed.

	reinstatement, shall reinstate the policy; provided, however, that if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.		
Legal Action page 44	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 policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. After two years from the date of issue of the policy no misstatements, except fraudulent misstatements, made by the applicant shall be used to void the policy or to deny a claim. 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 insured, 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 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	Updated language.

	After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy 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 this policy.	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.	
Proofs of Loss	Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.		Removed.
Relationship to Samaritan Health Services page 45	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. The group 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 group or the covered participants for any of our obligations to the group or the covered employees created under this Plan.	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.	Updated language.
Inmates and Juveniles in Detention Centers page 45		We will not deny reimbursement for any service or supply covered by the plan nor will we cancel the coverage of a	Added.

		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	
Physical Examination and Autopsy	The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.		Removed.
HIPAA/ADA	Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.		Removed.
GINA	The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.		Removed.
Certificate of Creditable Coverage	A covered person who ceases to be covered under the Plan will be provided a certificate that evidences the covered person's creditable coverage and the period of that creditable coverage, upon request. The time as of which the certificate will be provided and the contents of the certificate are explained below. **Creditable Coverage** is defined		Removed.

	as 180 days of continuous coverage with an applicable plan. **Provision of Certificate Upon Request** A covered person, or someone on behalf of a covered person, can request a certificate of creditable coverage at any time within 24 months of the date that coverage under the plan ended. A request for a certificate can be made even if a certificate was previously provided, including upon a prior request. A certificate provided upon request will disclose each period of continuous coverage that ceased during the 24-month period ending on the date of the request, or which was continuing on the date of the request. A separate certificate can be provided for each period of continuous coverage. **Specification of Benefits** A group health plan or issuer can request on behalf of a covered person who was previously provided a certificate of creditable coverage for specific information regarding categories of benefits that had been provided under the plan to the covered person. The plan can charge the requesting plan or issuer for the reasonable cost of providing such benefit information. Subject to the payment of such expenses, the Plan will promptly provide to the requesting entity all of the requested information that is reasonably available to the plan.		

NOTE: The information shared above are changes that may have affect your coverage or eligibility to receive coverage. There were other changes made to the Samaritan Everyday Choices endorsement that do not affect your coverage status or eligibility. Those minor changes were not included in this summary.