Samaritan Health Plans, Inc.

2019 group certificate and benefit changes

For Samaritan Momentum

Pending State Approval

EFFECTIVE
1/1/2019

Benefits

All plans

Specialty medications that were previously on Tiers 2-4 have been moved to Tier 5

Momentum 0% plans

- Added $7,900 plan option

Benefit	2018 Benefit	2019 Benefit
Partial hospitalization and Intensive Outpatient services for Substance use		In network: 0%, after deductible Out of network: Not covered
Bariatric surgery (Does not apply to maximum out-of-pocket)		In network: $5,000, not subject to deductible Out of network: Not covered
Specified surgical procedures	In network: 0%, after deductible Out of network: 50%, after deductible	In network: 0%, after deductible Out of network: Not covered

Momentum 20% plans

- Out-of-pocket maximum increased to $,7900 for the following plans:
  - Momentum $2000
  - Momentum $3000
  - Momentum $4000
  - Momentum $5000

Benefit	2018 Benefit	2019 Benefit
Partial hospitalization and Intensive Outpatient services for Substance use		In network: 20%, after deductible Out of network: Not covered
Bariatric surgery (Does not apply to maximum out-of-pocket)		In network: $5,000, not subject to deductible Out of network: Not covered
Specified surgical procedures	In network: 0%, after deductible Out of network: 50%, after deductible	In network: 20%, after deductible Out of network: Not covered

Momentum 30% plans

- Out-of-pocket maximum increased to $,7900 for the following plans:
  - Momentum $2000
  - Momentum $2500
  - Momentum $3000
  - Momentum $3500
  - Momentum $4000
  - Momentum $5000
  - Momentum $6850
  - Momentum $7150
  - Momentum $7350

Benefit	2018 Benefit	2019 Benefit
Partial hospitalization and Intensive Outpatient services for Substance use		In network: 30%, after deductible Out of network: Not covered
Bariatric surgery (Does not apply to maximum out-of-pocket)		In network: $5,000, not subject to deductible Out of network: Not covered
Specified surgical procedures	In network: 0%, after deductible Out of network: 50%, after deductible	In network: 30%, after deductible Out of network: Not covered

Momentum 50% plans

- Out-of-pocket maximum increased to $,7900 for the all plans.

Benefit	2018 Benefit	2019 Benefit
Partial hospitalization and Intensive Outpatient services for Substance use		In network: 50%, after deductible Out of network: Not covered
Bariatric surgery (Does not apply to maximum out-of-pocket)		In network: $5,000, not subject to deductible Out of network: Not covered
Specified surgical procedures	In network: 0%, after deductible Out of network: 50%, after deductible	In network: 50%, after deductible Out of network: Not covered

HSA plans

- Added HSA 2700 and HSA 6750 plan options
- Removed HSA 6550 plan option
- Out-of-pocket maximum increased to $6,750 for the following plans:
    - HSA2500
    - HSA 3500
    - HSA 5250

HSA 2500, HSA 2700, HSA 3500, HSA 5250

Benefit	2018 Benefit	2019 Benefit
Partial hospitalization and Intensive Outpatient services for Substance use		In network: 20%, after deductible Out of network: Not covered
Bariatric surgery (Does not apply to maximum out-of-pocket)		In network: 20%, after deductible Out of network: Not covered
Specified surgical procedures	In network: 0%, after deductible Out of network: 50%, after deductible	In network: 20%, after deductible Out of network: Not covered

HSA 4000, HSA 6750

Benefit	2018 Benefit	2019 Benefit
Partial hospitalization and Intensive Outpatient services for Substance use		In network: 0%, after deductible Out of network: Not covered
Bariatric surgery (Does not apply to maximum out-of-pocket)		In network: 0%, after deductible Out of network: Not covered
Specified surgical procedures	In network: 0%, after deductible Out of network: 50%, after deductible	In network: 0%, after deductible Out of network: Not covered

Prior Authorization

The Prior Authorization list has been removed from the certificate and will be available on the website.

The following updates were made to the 2019 Prior Authorization list:

2018 Prior Authorization list	2019 Prior Authorization list	Summary of change
Bariatric surgery	Bariatric surgery (benefit is for in-network services only)	Updated language.
Capsule Endoscopy	Capsule/wireless endoscopies and motility monitoring studies	Updated language.
Durable Medical Equipment (DME) including prosthesis, oxygen and oxygen supplies, with line item prices over $1,000 in rental or purchase fees or rentals over (3) months	Durable Medical Equipment (DME) and supplies, prosthetics, and orthotics with billed amount greater than $1000 for purchase. Rental items with rental fee greater than $1000 per month or rental length greater than 3 months.	Updated language.
	Hyperbaric oxygen therapy	Added.
	Infused/injected medications (see attached list)	Added.
Inpatient hospital care: Exception: Maternity delivery services Exception: Labor & delivery Exception: Newborn less than 5 days	Inpatient hospital care (including mental health and substance use disorder) Exception: labor & delivery Exception: newborn stays less than 5 days	Updated language.
	Inpatient rehabilitation care	Added.
Cosmetic, reconstructive and/or experimental surgery and services, including clinical trials	Potentially cosmetic, experimental, or reconstructive surgery and services, including new and emerging technologies and clinical trials	Updated language.
Radiological services (for the following): Capsule Endoscopy CT Scan with Thorax; W/O Contrast (Code 71250) Low Dose CT Scan (LDCT) for Lung Cancer Screening (Code G0297) Magnetic Resonance Imaging (MRI) Positron Emission Tomography (PET) scans Virtual Colonoscopy	Radiological services (for the following): Magnetic Resonance Imaging (MRI) Positron Emission Tomography (PET) scans Virtual colonoscopy	Updated language.
Residential services for mental health and chemical dependency/substance abuse/detoxification	Residential services for mental health and substance use disorder	Updated language.
	Skin substitute – tissue engineered	Added.
Therapeutic abortions		Removed.
	Urine drug tests (prior authorization required after 12 units per year)	Added.

The following medical drugs have been added to the Prior Authorization list:

- Abatacept (Orencia)
- Abobotulinumtoxin A (Dysport)
- Adalimumab (Humira)
- Aflibercept (Eylea)
- Agalsidase Beta (Fabrazyme)
- Albiglutide (Tanzeum)
- Alemtuzumab (Campath, Lemtrada)
- Alglucosidase Alfa (Myozyme)
- Alpha-1 Proteinase Inhibitor (Aralast NP, Glassia, Prolastin-C, Zemaria)
- Antihemophilic Factor (Hemofil M, Koate, Monoclate-P)
- Belatacept (Nulojix)
- Belimumab (Benlysta)
- Bevacizumab (Avastin)
- Bortezomib (Velcade)
- C1 Esterase Inhibitor (Berinert, Cinryze, Haegarda, Ruconest)
- Certolizumab (Cimzia)
- Cetuximab (Erbitux)
- Coagulation Factor IX (Idelvion)
- Coagulation Factor VIIa (NovoSeven RT)
- Collagenase, Injectable (Xiaflex)
- Daratumumab (Darzalex)
- Denosumab (Prolia, Xgeva)
- Eculizumab (Soliris)

- Edetate (EDTA) Chelation
- Elotuzumab (Empliciti)
- Epoetin and Darbepoetin (Epogen, Procrit, Aranesp)
- Epoprostenol (Flolan, Veletri)
- Etanercept (Enbrel)
- Fulvestrant (Faslodex)
- Glatiramer Acetate (Copaxone, Glatopa)
- Golimumab (Simponi, Simponi Aria
- Granulocyte Colony-Stimulating Factor (G-CSF) (filgrastim, Granix, Neupogen, Zarxio)
- Granulocyte-Macrophage Colony-Stimulating Factor (GMCSF) (sargramostim, Leukine)
- Hyaluronic Acid, Intra-articular Injection (Durolane, Gel-One)
- Icatibant (Firazyr)
- Idursulfase (Elaprase)
- Imiglucerase
- Immune Globulin Intravenous (IVIG, Bivigam, Carimune, Cuvitru, Gammagard, Octagam, Privigen)
- Infliximab (Remicade, Inflectra, Renflexis)
- Interferon and Peginterferon (Intron A, Avonex, Betaseron, Extavia, Rebif, Pegasys)
- Ipilimumab (Yervoy)
- Lanreotide (Somatuline)
- Laronidase (Aldurazyme)
- Mecasermin (Increlex)
- Mepolizumab (Nucala)
- Natalizumab (Tysabri)
- Nivolumab (Opdivo)
- Octreotide (Sandostatin)
- Ocrelizumab (Ocrevus)
- Omalizumab (Xolair)
- OnabotulinumtoxinA (Botox)
- Oprelvekin (Neumega)
- Palifermin (Kepivance)
- Palivizumab (Synagis)
- Palonosetron (Aloxi)
- Panitumumab (Vectibix)
- Pasireotide (Signifor)
- Pegaptanib (Macugen)
- Pegloticase (Krystexxa)
- Pegvisomant (Somavert)
- Pembrolizumab (Keytruda)
- Pertuzumab (Perjeta)
- Ranibizumab (Lucentis)
- RimabotulinumtoxinB (Myobloc)
- Rituximab (Rituxan)
- Romiplostim (Nplate)
- Secukinumab (Cosentyx)
- Somatropin (Genotropin, Humatrope, Norditropin, Saizen, Omnitrope, Nutropin)
- Taliglucerase (Elelyso)
- Teduglutide (Gattex)
- Teriparatide (Forteo)
- Tocilizumab (Actemra)
- Trastuzumab (Herceptin)
- Ustekinumab (Stelara)
- Vedolizumab (Entyvio)
- Velaglucerase (Vpriv)

Member Certificate

NOTE: The information shared are changes that may have an effect on your coverage or eligibility to receive coverage. There were other changes made to the Samaritan Momentum certificate that do not affect your coverage status or eligibility. Those minor changes were not included in this summary.

- Pharmacy definitions have been moved to the 'Prescription Drug Benefits' section
- 'Preventive Care Services' section has been split into 'Preventive Care Services', 'Women's Preventive Care Services', and 'Reproductive Health Care Services'
- The Prior Authorization list has been removed from the certificate and will be available on the website.
- The HIPAA Privacy Notice has been removed from the certificate. This information will be sent out with member materials, separate from the certificate.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
	This document describes the Medical and Pharmacy benefits for eligible participants of the Plan Sponsor. We guarantee to offer to any employer all products that are approved for sale in the applicable market, and must accept any employer that applies for any of those products where eligible. We guarantee coverage based on eligibility and provisions of this document, not based on health status, race, creed, genetic information, sexual orientation, or disability in accordance with Oregon Statute. 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, Patient Protection and Affordable Care Act (PPACA) of 2009 and Oregon Revised Statutes.	**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 Medical, and Pharmacy benefits for eligible participants issued by Samaritan Health Plans to the Policyholder. 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** 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**		Removed.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
	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 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).	Added.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
		Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.	
Definitions page	**Allowed amount** – This is the maximum amount that is payable to the provider of service for medically necessary, covered services. This amount is the combination of the Samaritan Health Plans payment and any deductible, coinsurance, or copayment owed by the member. Amounts allocated to deductible, coinsurance, or copayments are so indicated by the Explanation of Benefits. 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'.	**Allowed amount** – The maximum amount that is payable to the provider of service for medically necessary covered services. For an in-network provider, the allowed amount is the amount that the provider has agreed to accept for a particular service. For an out-of-network provider, the allowed amount is the amount that Samaritan Health Plans has determined to be the usual, customary and reasonable charge for the particular service. For questions regarding the basis for the determination of the allowed amount, please contact Member Services.	Updated language.
Definitions page	**Ambulatory surgical center** – A facility licensed by the appropriate state or federal agency to perform surgical procedures on an outpatient basis.	**Ambulatory surgical center** – A facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.	Updated language.
Definitions page	**Annual enrollment** – A period of time each year when eligible employees can enroll in the Plan or make Plan changes.		Removed.
Definitions page	**Appeal** or **Adverse Benefit Determination** – An insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's: • Denial of eligibility for or termination of enrollment in a health benefit 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	**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.	Updated language.
Definitions page		**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		**Authorized Services** – Means services or supplies that have been approved by the claims administrator.	Added.
Definitions page	**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 $100 and the allowed amount is $10, the provider may bill you for the remaining $90.	**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.	Updated language.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
	This happens most often when you see an out-of-network (non-preferred) provider. You cannot be balance billed if you receive covered services by an in-network provider. Effective March 1, 2018, you cannot be balance billed for emergency services, or if you receive covered services at an in-network inpatient or outpatient facility, and those services are provided by an out-of-network provider when the member did not choose to receive services from the out-of-network provider.	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. You also cannot be balance billed for emergency services, or if you receive covered services at an in-network inpatient or outpatient facility, and those services are provided by an out-of-network provider when you did not choose to receive services from the out-of-network provider.	
Definitions page	**Benefit year** – The benefit year for a group's coverage is based on the effective date listed in the 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	**Certificate of coverage** – Written legal description of the plan, also called your certificate or policy. This document is your written legal description of the plan.		Removed.
Definitions page	**Chemical dependency** – An addictive relationship a person has with any drug or alcohol agent. Chemical dependency can be either physical or psychological, or both, and interferes with a person's social, psychological or physical adjustment. Chemical dependency does not include dependence on tobacco products or food.	**Chemical dependency** – A substance-related disorder (including alcoholism), as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, (DSM-5), except for those related to foods, tobacco or tobacco products.	Updated language.
Definitions page	**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		**Claims administrator** – Samaritan Health Plans serves as the claims administrator with respect to claims made under this plan.	Added.
Definitions page		**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 page	**Complications of pregnancy** – Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean sections are not complications of pregnancy.	**Complications of pregnancy** – Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus.	Updated language.
Definitions page	**Contracted agency** – Any servicing provider with whom we have contracted to provide services and supplies under this contract.		Removed.
Definitions page	**Contracting durable medical equipment supplier** – A supplier of durable medical equipment that has contracted to provide services and supplies to you under this Plan.		Removed.
Definitions page	**Cosmetic surgery** – Designed to improve a person's appearance without improving function.		Removed.
Definitions page	**Covered expenses** – The amounts that this Plan pays for covered services.		Removed.
Definitions page		**Covered services** – A service or supply that is specifically described as a benefit of this plan.	Added.
Definitions page	**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		**Custodial care** – Is non-medical care that helps individuals with his or her activities of daily living,	Added.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
		preparation of special diets and self-administration of medication not requiring constant attention of medical personnel.	
Definitions page	**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 credit** – For mid-year carrier coverage changes, all accumulators will be transferred over when we have received all pertinent information to do so. Your deductible and out-of-pocket accumulators are based 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. Deductibles do not apply to preventive benefits. Both the deductible and out-of-pocket maximum are accumulated on a calendar year basis. For mid-year carrier coverage changes, all accumulators will be transferred over when Samaritan Health Plans has received all pertinent information.	Updated language. Deductible credit definition language has been added.
Definitions page		**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	**Durable Medical Equipment (DME)** – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wigs, wheelchairs, crutches or breast pumps.	**Durable Medical Equipment (DME)** – An item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness and/or injury, and is appropriate for use in your home. Examples include oxygen equipment and wheelchairs.	Updated language.
Definitions page	**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	**Eligible expense or charge** – The usual, customary or reasonable charge assessed on an itemized bill for medically necessary medical treatment as provided by this Plan.		Removed.
Definitions page	**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 page	**Enrollee** – An employee, dependent of the employee or an individual otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of this agreement. Enrollee is referred to as subscriber or member.		Removed.
Definitions page	**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 page	**Exclusions** – Specified conditions or circumstances, listed in this Plan, for which we pay no benefits. Exclusions can apply to services that are medically necessary, and where appropriate.		Removed.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
Definitions page	**Exclusion period** – A period during which specified treatments or services are excluded from coverage.		Removed.
Definitions page		**Gender dysphoria** – An individual's internal sense of being a gender different from the gender assigned to the individual at birth, a transgender person or neither male or female. The plan does not discriminate against members on the basis that a treatment is for gender dysphoria issues.	Added.
Definitions page		**Genetic information** – Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.	Added.

Definitions page	**Grievance** – 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:
	1. In writing, for internal appeal or an external review
	2. 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, the employer group, or Plan Sponsor, and Samaritan Health Plans
		Grievance – Means either of the following:
		A communication from a member or authorized representative of a member expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:
		• In writing, for internal appeal or an external review
		• In writing or orally, for an expedited response or an expedited external review
		• A written complaint submitted by a member or authorized representative regarding the:
		  o Availability, delivery or quality of health care service
		  o 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
		  o Matters pertaining to the contractual relationship between a member, employer, and Samaritan Health Plans
			Updated language.

Definitions page		**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		**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, vision plans, health statements or riders, and any information incorporated or submitted as part of the Application for this Group Policy.	Added.
Definitions page	**Home health care** – Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurse, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.	**Home health care** – Services and supplies that a licensed home health agency provides to a homebound patient. Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurse, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.	Updated language.

Section and Page	2018 member certificate	2019 member certificate	Summary of change
Definitions page	**Hospice** – Services designed to provide comfort and support for persons in the last stages of a terminal illness and their families.	**Hospice** – Services designed to provide comfort and supportive services to terminally ill patients and their families.	Updated language.
Definitions page	**In-network** – The covered services that you receive from providers that are contracted with Samaritan Health Plans to provide services for our commercial members.	**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	**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	**Injury** – A personal bodily injury to a covered person caused solely by external, violent, and/or accidental means.	**Injury** – A personal bodily injury to you caused directly and independently of all other causes by external, violent, and/or accidental means.	Updated language.
Definitions page	**Late enrollee** – An individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if: a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on February 17, 2009 b) The individual applies for coverage during an open enrollment period c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan		Removed.
Definitions page	**Maximum out-of-pocket** – The maximum amount you will incur in a calendar year before the Plan begins paying at 100% for eligible medical costs.		Removed.
Definitions page	**Medical emergency** – A medical emergency is an injury or sudden illness so severe that a prudent layperson would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person (or fetus). Examples of medical emergencies include (but are not limited to): • bleeding that does not stop • sudden abdominal or chest pains • suspected heart attacks • broken bones • serious burns • onset of delivery • severe pain		Removed.
Definitions page	**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	**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	Updated language.

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	treating an illness, injury, disease, or its symptoms, are: • In accordance with generally accepted standards of medical practice • Clinically 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's determination as based on available information and documentation, and in accordance with the terms of the Plan 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 can 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.**	treating an illness, injury, disease, or its symptoms, are: • In accordance with generally accepted standards of medical practice; • Clinically appropriate or medically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; • Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease; • In Samaritan Health Plan's determination as based on available information and documentation, and in accordance with the terms of the plan; and • The least costly of the alternative supplies or levels of service which can be safely provided to the patient. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the patient's home, without harm to the patient. Services and supplies intended to diagnose or screen for a medical condition are not considered medically necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing. Medically necessary care does not include custodial care. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors. The fact that a physician can 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	**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.

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Definitions	**Network** – Facilities, providers and suppliers your health insurer or Plan has contracted with to provide health care services.		Removed.
Definitions	**Obesity** – A condition in which a person has a body mass index of at least 30.0 kg/m2 but less than 40.0 kg/m2.		Removed.
Definitions page		**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	**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** – Hospitals, physicians, providers, professionals and facilities 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 usual, customary and reasonable charge (UCR) for the service provided.	Updated language.
Definitions page	**Out-of-pocket limit** – The most you pay for covered services during a calendar year before your health insurance or Plan begins to pay 100% of the allowed amount. This limit never includes our premium, balance billed charges or services your health insurance or Plan doesn't cover. Some health insurance or plans do not count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses towards this limit. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year.	**Out-of-pocket limit** – The maximum amount you must pay for essential health benefits and non-essential health benefits (for example, for deductibles, coinsurance and co-pays) during a calendar plan year before the plan begins to pay 100% of the allowed amount. The out-of-pocket limit for a calendar year will not exceed the annual cost sharing limit for such year as set by established by the U.S. Centers for Medicare and Medicaid. The out-of-pocket limit is accumulated on a calendar year.	Updated language.
Definitions page		**Participant** – An employee, or a former employee (such as an employee receiving COBRA continuation coverage) who is enrolled in the plan.	Added.
Definitions	**Patient Protection and Affordable Care Act (PPACA)** – A federal statute that was signed into law in the United States by President Barack Obama on March 23, 2010, along with the Health Care and Education Reconciliation Act of 2010. The Act is the product of the health care reform agenda and includes numerous health-related requirements that a health plan is required to adhere to.		Removed.
Definitions page	**Plan** – Samaritan Health Plans, or "Samaritan", the insurance carrier who issues the Member Certificate(s) as sponsored by the Employer group. Health coverage issued to you through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called 'health insurance plan', 'policy', 'health insurance policy', or 'health insurance'.	**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 support programs** – We have the capability to develop support programs to compliment the medical advice of your healthcare provider.		Removed.
Definitions	**Plan term** – The group plan becomes effective at 12:01 a.m. on the date written in the member 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		Removed.

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	renewed from month to month thereafter unless modified or terminated.		
Definitions	**Policy** – This Agreement, Group's Contract Application, the Policy, and Member Certificates incorporated herein by reference, and any amendments, exhibits, supplements, addenda, attachments, endorsements, applications, Vison plans, health statements or riders, 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 page	**Preauthorization** – A decision by your health insurer or Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or Plan can require preauthorization for certain services before you receive them, where appropriate, except in an emergency. Preauthorization isn't a promise your health insurance or Plan will cover the cost.	**Prior authorization** – A decision by Samaritan Health Plans that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Samaritan Health Plans can require prior authorization for certain services before you receive them, except in an emergency. See the Prior Authorization section of this Group Certificate.	Updated language.
Definitions	**Pre-existing condition** – A health benefit plan 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 pre-existing conditions clause.		Removed.
Definitions	**Premium** – The amount that must be paid for your health insurance or Plan. You and/or your employer pay a portion every month. Premiums do not accumulate towards your out-of-pocket maximums or deductibles.		Removed.
Definitions	**Prescription medication** – Medications and biologicals that relate directly to the treatment of an illness or injury and that can legally be dispensed only with a prescription order. By law, they must bear the legend: "Caution – federal law prohibits dispensing without prescription." For purposes of the outpatient prescription medication benefit, prescription medications also include covered insulin and supplies used for the administration of insulin, Self-injectable medications, and compound medications. We require a prescription order for insulin and diabetic supplies.		Removed.
Definitions	**Preventive care** – Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.		Removed.
Definitions	**Primary care home** – The Primary Care Home (PCH) practice provides relationship-based, primary health care that focuses on the health needs of the whole person. The PCH is responsible for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. They coordinate care across all elements of the broader health care system, including		Removed.

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	specialty care, hospitals, home health care, and community services.		
Definitions page	**Primary care provider (PCP)** – Can mean, and is not limited to a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), Pediatric physician, Family medicine, OB-GYN physician, Internal medicine, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services for the indicated specialties.	**Primary care provider (PCP)** – Can mean, and is not limited to, a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), Pediatric physician, Naturopathic physician, Family medicine, OB-GYN physician, Internal medicine, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services for the indicated specialties within the scope of their care.	Updated language.
Definitions page	**Professional provider** – Licensed or Registered Medical Providers that provide Medically Necessary covered services within the scope of their license or registry. Professional provider can mean, and is not limited to mean, any of the following, for medically necessary services, which are within the scope of the professional provider's state license or registry: • Acupuncturist, massage therapist, chiropractor • Naturopathic doctor or physician • A physician (doctor of medicine or osteopathy) • podiatrist • dentist (doctor of medical dentistry, doctor of dental surgery, dental hygienist with expanded practice or denturist) • pharmacist • psychologist • optometrist • Oregon-registered clinical social worker and counselors, including and when acting within the scope of their practice, professional counselors, marriage and family therapists licensed under ORS 675.715 to 675.835. • certified nurse practitioner • registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient • physician assistant (to be paid as if submitted by the supervising physician) • Registered physical, occupational, speech, or Audiological therapist • Women's health care provider or pediatrician Samaritan Health Plans does not discriminate against providers acting within the scope of their own licensure or certification.	**Professional provider** – Can mean, and is not limited to mean, any of the following for medically necessary services which are provided within the scope of the professional provider's state license or registry: • Acupuncturist, massage therapist, chiropractor • Naturopathic doctor or physician • A physician (doctor of medicine or osteopathy) • Podiatrist • Dentist (doctor of medical dentistry, doctor of dental surgery, or denturist) and for an expanded practice dental hygienist • Pharmacist • Psychologist • Optometrist • Clinical social worker and counselors • Certified nurse practitioner • Registered nurse or licensed practical nurse, but only for those services for which nurses customarily bill a patient • Physician assistant (to be paid as if submitted by the supervising physician) • Registered physical, occupational, speech, or Audiological therapist • Women's health care provider or pediatrician Samaritan Health Plans does not discriminate against professional providers acting within the scope of their own licensure or certification.	Updated language.
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		**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	Added.

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		Registered Domestic Partnership by the Clerk of an Oregon County 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. The same rights and benefits provided to spouses under the plan will be provided on the same terms to covered domestic partners. 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.	
Definitions page	**Service area** – Samaritan Momentum Plan options are available for purchase statewide in the State of Oregon for Oregon domiciled businesses.	**Service area** – Samaritan Health Plan options are available for purchase statewide in the State of Oregon for businesses domiciled with at least 50.1% of employees residing in Oregon.	Updated language.
Definitions page		**Specialist provider** – Services provided by any provider who is not defined as a primary care provider. A primary care provider visit is defined as services provided by a Pediatric, Family Medicine, Internal Medicine or OB-GYN provider.	Added.
Definitions	**Spell of illness** – The duration of a particular illness that lasts for a period of consecutive days beginning with the first day, not part of a previous illness on which you are admitted to a hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a hospital inpatient nor been confined in any other type of facility.		Removed.
Definitions page	**Spouse** – To whom you are married and/or your domestic partner.	**Spouse** – The person to whom you are legally married.	Updated language.
Definitions page		**Tobacco use** – Defined as the use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.	Added.
Definitions page		**Tobacco Use Cessation Program** – A program offering an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. Tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.	Added.
Definitions page	**Waiting period** – Group eligibility waiting period means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins. Waiting periods, defined by 45 CFR § 147.116, may not exceed 90 days.	**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.	Updated language.
Definitions	**When coverage begins** – • The first of the month after we have received your completed enrollment materials from the Plan Sponsor, after any applicable waiting periods		Removed.

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	• In the case of a 90 day waiting period, the 91st day • 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		
General Provisions	**Samaritan Health Plans is NOT responsible for the following administrative services:** Eligibility and Enrollment **Eligibility criteria** Eligibility and enrollment are determined and processed through your employer. You will need to contact your employer to determine whether or not you meet the eligibility criteria to be enrolled on to this plan. **Disenrollment** Your Plan Sponsor 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 the Plan. • You did not pay your premium on time and are no longer eligible for the Plan. • 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.
Deductibles and Out-of-Pocket Maximums	This is only a brief summary of benefits. Please refer to the additional information throughout this Certificate for further explanations of your benefits including limitations and exclusions. Your Annual Out-of-Pocket Limit This plan has an out-of-pocket limit to protect you from excessive medical expenses. The Benefit Schedule shows your plan's annual out-of-pocket limit. If you incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to these covered benefits, according to your Benefit Schedule. The in-network and out-of-network out-of-pocket accumulate separately and are not combined. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year. **Expenses for the Following DO NOT Count Toward Your Out-of-Pocket Limit:** • Charges over usual, customary, and reasonable amounts • Benefits paid in full		Removed.

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	• Incurred charges that exceed amounts allowed under this plan • Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan • Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims) • Bariatric and Gastric banding surgery copays • Other services called out in any plan document Information About Your Deductible **Deductible** This is the portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide benefits. The deductible amount for individuals and families is listed in your Benefit Schedule. No family will have to satisfy more than the Family Deductible each calendar year. The in-network and out-of-network deductible accumulate separately and are not combined. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year. Some services do not apply to your deductible obligation. To find out which services will or will not apply to your deductible, see your Benefit Schedule or call our Member Services representatives at 541-768-4550 or toll free 1-800-832-4580. **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. **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.		
Health Savings Account (HSA) Eligibility	Some Samaritan Momentum Plans meet the definition of a High Deductible Health Plan (HDHP) and are eligible for HSA plans in these instances: • When the deductible amount is $1,300 for an individual and $2,600 for a family or higher, making the plan a High-Deductible Health Plan (HDHP). All covered services outlined in this plan, unless specifically identified, apply to the deductible. The Benefit Schedule also outlines those services that apply to your deductible. • When the out-of-pocket limit is $6,550 for an individual and $13,100 for a family or higher, making the plan a High-Deductible Health Plan (HDHP). HSA Rules under Samaritan Health Plans: 1. Once the deductible has been met your copays and coinsurances will begin. You are not responsible for paying your copay or coinsurance UNTIL your deductible has been met. 2. Any contributions made on behalf of your employer will be added to your accumulating deductible amounts. **NOTE:** Not all plans meet the criteria; please contact your Plan Sponsor if you have any questions regarding your coverage.		Removed.
Enrollment Period	Please refer to your Plan Sponsor for enrollment periods and dates. There is no exclusion period administered by Samaritan Health Plans.		Removed.

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Provider Directory page	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.	You can find information on participating providers: • On the Samaritan Health Plans website. Go to www.samhealthplans.org/groupfindcare • 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.	Updated language.
Member Portal page	Your member portal at MyHealthPlan.samhealth.org provides you with secure, 24/7 access to: • Provider directories • Claims processed by your health plan • Details about your eligibility with the health plan, including the amount you have met toward your deductibles and your Plan limits. For questions about your member portal and technical support if needed, please call the Member Services Department at 541-768-4550, toll-free 1-800-832-4580 (For Hearing Impaired, call 1-800-735-2900), Mon.–Fri., 8 a.m. to 8 p.m. The Member Services Department can also be reached via email at MemberServices@samhealth.org.	Your member portal at www. MyHealthPlan.samhealth.org provides you with secure, 24/7 access to: • Claims processed by your health plan • Details about your eligibility with the plan, including the amount you have met toward your deductibles and your coverage limits. For questions about your member portal and technical support if needed, please call the Member Services Department at 541-768-4550, toll-free 1-800-832-4580 (For Hearing Impaired, call 1-800-735-2900), Mon.–Fri., 8 a.m. to 8 p.m. The Member Services Department can also be reached via email at MemberServices@samhealth.org.	Updated language.
Large Employer Group	A large employer group is an employer that employed an average of at least 51 or more employees on business days during the preceding calendar year, the majority of whom are employed within this state.		Removed.

Family Members page	While you are eligible and insured under the Plan, the following family members are also eligible for coverage:
	• Your legal spouse or 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.
	  o Samaritan Health Plans requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
	• Any dependent children until they reach the age of 26, and for purposes of coverage under the Plan, the term "child" includes:
	  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
		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 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;
		• Yours, 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
			Updated language.

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	○ 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 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. No family or household members other than those listed above are eligible to enroll under your coverage. Dependent parents, foster children, and any other relative not described above are not eligible for coverage under the Plan. Grandchildren are covered under the Plan only if they have been adopted or placed with you for adoption or for whom you have legal guardianship.	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 relatives who are 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.	
Retirees page		Retirees A retiree is eligible to enroll and remain in the plan only if he or she: • Is not Medicare eligible, and; • [Is a retired employee of the [Group] [participating employer] who has retired from service, and;] • [Is eligible to receive retirement benefits under the Public Employees Retirement System (PERS), and;] • [Has worked for the [Group] [participating employer] at least [1-20] continuous years immediately before retirement, and;] • [Meets the retiree eligibility rules as required by the [Group] [participating employer] and approved by Samaritan Health Plans] A retiree may enroll or add dependents upon retirement by submitting an enrollment application within 30 days of retirement. Coverage will be effective the first day of the following month. At the time of retirement or any day thereafter, if a retiree declines or terminates coverage for the retiree and/or dependents, that decision is irrevocable. Retirees may opt-out or remove dependents from the plan at any time and for any reason, but the option for coverage cannot be reinstated.]	Bracketed section added. Section and variables determined by employer group.
How and When to Enroll: When You First Become Eligible page	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 can be subject to a waiting 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 enrolling family members. Return the application to your employer, and your employer will send it to	The initial coverage eligibility date for you and your enrolling family members is in accordance with the eligibility rules established by your employer. Coverage will only begin if we receive your enrollment application with your employer's premium payment for that month. In order to become enrolled as of that initial eligibility date, you must enroll within the 30 day period following the eligibility date. If you do not enroll within this initial enrollment period, you must wait until the next open enrollment period to enroll, unless you incur a special enrollment event discussed below. To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the	Updated language.

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	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 Plan Sponsor's probationary waiting period. For 90 day waiting periods, coverage will begin the 91st day. Check with your Plan Sponsor 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 to your employer, and your employer will send it to Samaritan Health Plans.	
Open Enrollment page		The open enrollment period is the only time, other than initial eligibility or a special enrollment period, during which you and /or your eligible dependents may enroll in the plan. You must submit to your employer an enrollment form on behalf of all individuals you want enrolled. If you do not enroll within this open enrollment period, you must wait until the next open enrollment period to enroll, unless you incur a special enrollment event discussed below.	Added.
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 stated. The newly eligible employee must complete and submit to the Plan Sponsor 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. For 90 day waiting periods, coverage will begin the 91st day.		Removed.
Mid-Year Special Enrollment – Newborns page	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 may 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. 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.	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 an 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. The premium is charged from the date of birth and prorated for the first month. If no additional premium is required, then the baby's eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.	Updated language.
Mid-Year Special Enrollment – Adopted Children page	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.	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.	Updated language.

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	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.	If an 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. The premium is charged from the date of placement and prorated for the first month. If no additional premium is required, then the child's eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.	
Mid-Year Special Enrollment – Family Members Acquired by Marriage page	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 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 marriage. You can be required to submit a copy of your marriage certificate to complete enrollment. This health benefit plan does not discriminate between married and unmarried women or between children of married and unmarried women.	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 Domestic Partnership page	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 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.	If you are enrolled in the plan, you may enroll a new qualified domestic partner and any eligible dependent children of the domestic partner. The enrollment must be made during the 30 day period from the date of the domestic partnership. Samaritan Health Plans must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new qualified domestic partner and any eligible dependent children of the domestic partner will then begin on the first day of the month after the beginning of the partnership. You can be required to submit information requested by the employer evidencing the qualification of the domestic partnership to complete enrollment.	Updated language.
Returning to Work After a Leave of Absence (LOA) page	If you return to work after an employer-approved leave of absence of nine months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume coinciding with the date of return from LOA and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application to Samaritan Health Plans within the 30 day initial enrollment period following your return to work. Failure to submit the application within the 30 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.	If you return to work after an employer-approved leave of absence of nine months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume coinciding with the date of return from LOA and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application to Samaritan Health Plans within the 30 day initial enrollment period following your return to work. Failure to submit the application within the 30 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.	Section is now bracketed. Inclusion of language will be determined by employer group.
Waiver of Coverage	The employee may waive coverage under the Plan for themselves or any eligible dependents. If the employee waives coverage for themselves, the employee's dependents are not eligible for coverage. To waive coverage, the employee must turn in the Enrollment Change/Waiver form to the Plan Sponsor, specifying the reason for the waiver. The form must list by name		Removed.

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	each of the dependents for which the employee waives coverage.		
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 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.		Removed.
Returning to Work After a Layoff	If you are laid off and then rehired by your employer within nine months, you will not have to satisfy another probationary waiting period. Your health coverage will resume coinciding with the date of return to work from layoff and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application to Samaritan Health Plans within the 30 day initial enrollment period following your return to work. Failure to submit the application within the 30 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.		Removed.
Other Special Enrollment Events page	Some employers have agreements with Samaritan Health Plans allowing employees with other health coverage to waive this Plan's coverage. 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 Plan Sponsor. The employee and family members can enroll in this Plan later if the employee qualifies under Rule #1, Rule #2, or Rule #3 below. If the agreement between Samaritan Health Plans and the Plan Sponsor 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 Rule #1, Rule #2, or Rule #3 below. Talk to your Plan Sponsor to find out if they allow employees to decline coverage.	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 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 Rule #2	If the employee acquires new dependents because of marriage, domestic partnership, birth, or placement for adoption, the employee can enroll themselves and/or your newly acquired dependents at that time. To do so, the employee must request enrollment within 30 days		Removed.

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	after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.		
HIPAA Special Enrollment Notice	If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, court –appointed guardianship or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009, supplements the HIPAA special enrollment notice by allowing eligible employees and dependents to enroll under the plan under the following circumstances: • The employee's, spouse, domestic partner, or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility • The employee, spouse, domestic partner, or dependent becomes eligible for a premium assistance subsidy or Medicaid coverage under Medicaid or Children's Health Insurance Program (CHIP). Employees and dependents must request special enrollment under this provision within 60 days of the loss of Medicaid or CHIP coverage or within 60 days after the employee or dependent is determined to be eligible for a Medicaid or CHIP subsidy. To request special enrollment or to obtain more information, contact your designated Human Resources department for more information.		Removed.
Late Enrollment	If the employee did not enroll during the initial enrollment period and does not qualify for a special enrollment period, enrollment will be delayed until the Plan's anniversary date. 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 the Plan Sponsor during an open enrollment period designated by the Plan Sponsor, just prior to the Plan's anniversary date. When the employee and/or employee's dependents enroll during the open enrollment period, plan coverage begins on the Plan's anniversary date.		Removed.

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Qualified Medical Child Support Order (QMCSO) page	Samaritan Health Plans 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 health 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.	Updated language.
Termination of Coverage page	If you leave your job for any reason or your work hours are reduced below your Plan Sponsor'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 State and Federal continuation coverage for more information. Any termination of coverage will be based on your date of termination, in which case, coverage will term the end of the month you were terminated. 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 State and Federal 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 submitting it to your Plan Sponsor. Keep in mind that once coverage is discontinued, your family members may not be able to enroll until the next enrollment period.	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 State and Federal 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.
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 Sponsor to determine coverage changes.		Removed.
Termination of Group	Samaritan Health Plans must receive written notice of termination from the Group. Samaritan Health Plans must receive the notice at least 30 days in advance of the proposed termination date. Group must provide in writing whether Samaritan Health Plans is being replaced by another group policy. Group shall continue to be liable for Plan premiums for all Members enrolled		Removed.

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	in Plan through Group through the end of the first full month requested and agreed upon termination date.		
Dependent Children page	When your enrolled child no longer qualifies as a dependent, coverage will end the last day of the month in which the dependent attains the age of 26. See Your eligibility for information on when your dependent child is eligible beyond age 25. See State and Federal continuation 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 State and Federal continuation coverage where you can find more information on other coverage options for those who no longer qualify for coverage.	Updated language.
Certificates of Creditable Coverage	For questions or requests regarding certificates of creditable coverage, you will need to contact your Plan Sponsor.		Removed.
Federal COBRA Continuation	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 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 Plan Sponsor 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.	If your employer has 20 or more employees, you and/or your spouse and eligible dependents may be eligible to continue health care coverage under the plan 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. **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:	Updated language. Inclusion of bracketed language will be determined by employer group.

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		• 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 or reduction in h Employee's divorce or legal separation Employee's eligibility for Medicare benefits if it causes a 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.	

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		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 or domestic partner and eligible children in your family can get up to 18 additional	

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		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	

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		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.	
Continuation for Spouses over Age 55	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 Plan Sponsor 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 Plan Sponsor to verify your continuation coverage benefits. 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.	Subject to the general provision of the plan, if you die or 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 (or dissolution of domestic partnership) • Sixty days of the date of entry of the divorce decree [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.]	Updated language. Inclusion of bracketed language will be determined by employer group.
Continuation after Injury or Illness Covered by Workers' Compensation		If you have an injury or illness covered by workers' compensation, you may continue your coverage under this plan by self-paying the health plan premium until the earliest of the following dates: You take full-time employment with another employer Six months from the date you first pay your health insurance premium under this provision Continuation under this provision will be concurrent with COBRA continuation for the period that you are also eligible for COBRA continuation.	Added.
Work Stoppage page	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. This Plan provides coverage in accordance with the Oregon Revised Statutes for a covered individual who is hospitalized on the date of termination of this Plan if it is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any	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.

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	payment required under this Plan pursuant to this section is subject to all applicable terms, limitations and conditions on benefits.		
Employer Contribution	Samaritan Health Plans cannot deny an employer's application for coverage under a health benefit plan based on participation or contribution requirements but can require employers that do not meet participation or contribution requirements to enroll during the open enrollment period. **For every group health benefit plan, the issuer 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.
Prescription medication exception page 34	You may ask us to make a medication exception to our coverage rules. This includes exceptions for: • Coverage of your drug even if it is not on the formulary • Waiving coverage restrictions or limits on your drug • Providing a higher level of coverage for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, we will not provide a higher level of benefit for that drug than you would be entitled to had you chosen a medication on the formulary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your medication exception request. If we approve your medication exception request, the approval time will be made on a case-by-case basis. We will continue to pay for the drug for the duration of the approval time, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your medication exception request, you can appeal our decision.	You may ask us to make a medication exception to our coverage rules. This includes exceptions for: Coverage of your drug even if it is not on the formulary; Waiving coverage restrictions or limits on your drug; and Providing a higher level of coverage for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, we will not provide a higher level of benefit for that drug than you would be entitled to had you chosen a medication on the formulary. Exception approvals for standard non-formulary medications will process at the highest non-specialty co-pay. Exception approvals for non-formulary specialty drugs will process at the highest specialty co-pay. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your medication exception request. If we approve your medication exception request, the approval time will be made on a case-by-case basis. We will continue to pay for the drug for the duration of the approval time, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your medication exception request, you can appeal our decision.	Updated language.
Usual and customary charges (UCR)	Part of the definition of Covered Charge and, therefore, part of the basis upon which this Plan pays for Covered Services, taking into consideration fee(s) which the Health Care Provider most frequently charges the majority of patients for the service or supply, the cost to the Health Care Provider for providing the services, the prevailing range of fees charged in the same "area" by Health Care Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to		Removed from Prescription Drug Benefits section.

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	obtain a representative cross-section of Health Care Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be "usual and customary", fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The term "usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred. The term "customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age, and who receive such services or supplies within the same geographic locale. Usual and Customary Rates may alternatively be determined and established by the Plan using normative data including Medicare cost-to-charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.		
Chemical dependency services page 38	This Plan covers treatment provided in healthcare facilities, residential program or facilities, day or partial hospitalization programs, or outpatient services. See also Mental health and chemical dependency/substance abuse services. Samaritan Health Plans covers services and treatment for those mental health and chemical dependency/substance abuse diagnoses covered under the Mental Health Parity Act. Samaritan Health Plans is compliant with state and federal mental health parity.	The plan covers treatment [, other than for substance use or abuse,] provided in healthcare facilities, residential program or facilities, day or partial hospitalization programs, or outpatient services. [Outpatient intensive services and programs, including partial hospitalization, for substance use or abuse is covered in-network only.] See also Mental health and chemical dependency/substance abuse services. The plan covers services and treatment for those mental health and chemical dependency/substance abuse diagnoses covered under the Mental Health Parity Act. The plan is compliant with state and federal mental health parity.	Updated language. Inclusion of bracketed language will be determined by employer group.
Dental services page 40	Services of a dentist or physician, to treat an injury of the jaw or natural teeth may be covered under this Plan as a medical benefit. Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue. The following major dental procedures may be reimbursable as a medical benefit: • Multiple extractions • Removal of impacted teeth • Tumors, benign & malignant • Leukoplakia & premalignant lesions • Trauma to jaw, acute damage to teeth, jaw fracture • Lacerations in mouth • Infection beyond tooth or gum • Facial cellulitis • Infection beyond tonsillar pillar	Of a dentist or physician, to treat an injury of the jaw or natural teeth may be covered under the plan as a medical benefit. Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue. Please see your Benefit Schedule for cost share information. Services may fall under different benefits, depending on how your provider bills. The following major dental procedures may be reimbursable under the plan as a medical benefit: • Multiple extractions • Removal of impacted teeth • Tumors, benign & malignant • Leukoplakia & premalignant lesions • Trauma to jaw, acute damage to teeth, jaw fracture • Lacerations in mouth • Infection beyond tooth or gum	Updated language.

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	• Systemic disease manifestation in mouth – Lichen planus, Sjögren's syndrome, etc. • Craniofacial abnormalities • When the patient has another serious medical condition that can complicate the dental procedure • When the service is found to be related to an accident or reconstructive procedure	• Facial cellulitis • Infection beyond tonsillar pillar • Systemic disease manifestation in mouth – Lichen planus, Sjögren's syndrome, etc. • Craniofacial abnormalities (dental and orthodontic services) • When the patient has another serious medical condition that can complicate the dental procedure • When the service is found to be related to an accident or reconstructive procedure	
Developmental and learning disabilities page 40	Services will be covered for developmental and/or learning disabilities. We will cover, for members who have been diagnosed with a pervasive developmental disorder, all medical services, including rehabilitation and habilitative services, which are medically necessary and are otherwise covered under the Plan. These services may have limitations and exclusions based on the provisions of the Plan and this document.	Services will be covered for developmental and/or learning disabilities. We will cover, for members who have been diagnosed with a pervasive developmental disorder, all medical services, including rehabilitation and habilitative services, which are medically necessary and are otherwise covered under the Plan. See Benefit exclusions for more information on services that are excluded. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services).	Updated language.
Diabetic equipment page 40		Is covered as a DME benefit. The following is considered diabetic equipment: diabetic pumps, glucose monitors, test strips, diabetic shoes and inserts, and diabetic shoe fitting. Diabetic supplies are considered a separate benefit from Diabetic equipment. Items including gauzes, lancets, syringes, needles and alcohol swabs are considered diabetic supplies. See Diabetic supplies for more information.	Added.
Diabetic supplies page 40, 41	Are covered and are defined as gauzes, syringes, needles, lancets, alcohol and alcohol swabs, betadine swabs, diabetic shoes and inserts as well as the fitting. See DME, Diabetic equipment for additional information. Some items can be purchased at a pharmacy.	Are covered and are defined as gauzes, syringes, needles, lancets, alcohol and alcohol swabs, betadine swabs. Some items can be purchased at a pharmacy. See also DME, Diabetic equipment for additional information.	Updated language.
Durable medical equipment page 41	Purchase or rental of durable medical equipment including crutches, wheelchairs, wigs, orthopedic braces, prosthetics, glucometers, and equipment for administering oxygen are covered. Durable medical equipment must be prescribed in writing by a licensed MD, DO, DDS, DMD, or DPM. If the purchase price is over $1,000 per line item, or if the item is to be rented for longer than three months, Samaritan Health Plans must prior authorize the expense. See also Artificial Limbs and Eyes for coverage specifics. See Benefit exclusions.	Purchase or rental of durable medical equipment including crutches, wheelchairs, orthopedic braces, prosthetics, glucometers, and equipment for administering oxygen are covered. Durable medical equipment must be prescribed in writing by a licensed MD, DO, DDS, DMD, or DPM. See the Prior Authorization list for more information. See also Artificial Limbs and Eyes for coverage specifics. See Benefit Exclusions.	Updated language.
Emergency services page 42	A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or unborn child in the case of a pregnant woman, in serious jeopardy; result in serious impairment to bodily functions; result in serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer can pose a threat to the health or safety of the woman or the unborn child. Medically necessary emergency care is covered at the in-network provider benefit shown on the Benefit	The plan covers care for medically necessary emergency conditions. Medically necessary emergency care is covered at the in-network provider benefit shown on the Benefit Schedule, even if you are treated at an out-of-network hospital. See Definitions for information about emergencies. **Emergency care for any reason does not require a prior authorization.**	Updated language.

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	Schedule, even if you are treated at an out-of-network hospital. See Definitions for information about emergencies. **Emergency care for any reason does not require a prior authorization.** **How do I access care in the event of an emergency?** If you experience an emergency situation, you should obtain care from the nearest appropriate facility, or dial 911 for help. **If there is any doubt about whether you require emergency treatment, you can always call your primary care provider for advice. The primary care provider is able to assist you in coordinating medical care and is an excellent resource to direct you to the appropriate care since he or she is familiar with your medical history.**		
Eating disorders page 42		Are covered as a mental health service.	Added.
Essential Health Benefits page 42		The ten categories of benefits defined by the Secretary of U.S. Department of Health and Human Services as Essential Health Benefits. See Definitions. **Please note that pediatric dental is not covered by the plan.**	Added.
Gastric bypass surgery page 42	Not covered for HSA plan members. Roux-en-Y, Laparoscopic Adjustable Gastric Banding, and Laparoscopic vertical sleeve gastrectomy **may be covered upon prior approval** when the following criteria are met: Inpatient hospital copay of $5,000, which does not include program educational fees. Copay does not apply to the member's annual out-of-pocket maximum or deductible and does not include copays for professional services (for example, office visits and/or surgery). 1. BMI greater than or equal to 40 kg/m2 **or** 2. BMI greater than or equal to 35 kg/m2 with <u>one</u> of the following comorbid conditions, which are expected to be improved with surgery: o Hypertension o Diabetes o Hyperlipidemia o Sleep apnea o Coronary artery disease o Documented weight loss of greater than 5% after entering Bariatric program 3. Psychological evaluation by psychologist or psychiatrist, approved by Bariatric Surgery Program documenting absence of psychopathology that would interfere with understanding or compliance with surgical program. Examples: personality disorder, uncontrolled substance abuse, uncontrolled major mood or thought disorder. OR Same evaluation demonstrates presence of psychological issues that are controlled and will not compromise surgical outcome. Note: Medical Insurance will pay for evaluation only. Mental health treatment is covered under mental health benefit, whether or not it is related to obesity. 4. Documentation of previous compliance with medical care and willingness to comply with	**Gastric bypass surgery** – See your Benefit Schedule for more information. Roux-en-Y, Laparoscopic Adjustable Gastric Banding, and Laparoscopic vertical sleeve gastrectomy **may be covered upon prior authorization for in-network providers only** when the following criteria are met: 1. BMI greater than or equal to 40 kg/m2 or 2. BMI greater than or equal to 35 kg/m2 with <u>one</u> of the following comorbid conditions, which are expected to be improved with surgery: a. Hypertension b. Diabetes c. Hyperlipidemia d. Sleep apnea e. Coronary artery disease f. Documented weight loss of greater than 5% after entering Bariatric program 3. Psychological evaluation by psychologist or psychiatrist, approved by Bariatric Surgery Program documenting absence of psychopathology that would interfere with understanding or compliance with surgical program. Examples: personality disorder, uncontrolled substance abuse, uncontrolled major mood or thought disorder. OR Same evaluation demonstrates presence of psychological issues that are controlled and will not compromise surgical outcome. Note: Medical Insurance will pay for evaluation only. Mental health treatment is covered under mental health benefit, whether or not it is related to obesity. 4. Documentation of previous compliance with medical care and willingness to comply with preoperative and postoperative treatment plans 5. No medical condition that would make the surgery unusually risky	Updated language. Benefit is an option and covered in-network only.

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	preoperative and postoperative treatment plans 5. No medical condition that would make the surgery unusually risky 6. Age 18 or older 7. Covered only at Good Samaritan Regional Medical Center through the Bariatric Surgery program, and subject to its policies and surgical criteria	6. Age 18 or older 7. Covered only at Good Samaritan Regional Medical Center through the Bariatric Surgery program, and subject to its policies and surgical criteria	
Hearing aids and/or Hearing assistive technology systems page 43	Are covered. Repairs or accessories to hearing aids will be paid through the annual limit. Batteries are not covered. This benefit is limited to 1 every 4 years for each impaired ear. The limit does not apply to HSA plan options.	Are only covered in accordance with the requirements of state and federal law. Contact Member Services for specific coverage requirements.	Updated language to align with state rule.
Inborn errors of metabolism page 43		Treatment and services of inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism when medically standard methods of diagnosis, treatment, and monitoring exist are covered. Nutritional supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders are covered. Medically necessary PKU formulas (nonprescription elemental enteral formula) for home use when ordered by your authorized physician are covered: • If the formula is medically necessary for the treatment of severe intestinal mal-absorption, inborn errors of metabolism that involve amino acids, carbohydrates and fat metabolisms. • If the formula comprises the sole or an essential source of your nutrition.	Added.
Inpatient hospital page 44	Medically necessary hospital inpatient services are covered. Charges for a semi-private hospital room are covered, and charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for septicemic-caused isolation. Please see the Prior Authorization list. Covered inpatient hospital services can include (but are not limited to): • Semi-private room • Cardiac care unit • Operating room • Anesthesia and post-anesthesia recovery • Respiratory care • Inpatient medications • Lab and radiology services • Dressings, equipment, and other necessary supplies • Delivery, post-partum, newborn care • Blood or blood products Charges for rental of telephones, radios or televisions, or for guest meals or other personal items, are not covered. We cover services by any approved hospital that is owned and operated by the State of Oregon and any state approved community mental health and developmental disabilities program.	Medically necessary hospital inpatient services are covered. Samaritan Health Plans must prior authorize coverage of all inpatient and residential treatment. Only emergency admissions are covered without prior authorization and then Samaritan Health Plans must be notified within 48 hours, or as soon as reasonably possible. Charges for a semi-private hospital room are covered, and charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for septicemic-caused isolation. Please see the Prior Authorization list of this document. Covered inpatient hospital services can include (but are not limited to): • Semi-private room • Cardiac care unit • Operating room • Anesthesia and post-anesthesia recovery • Respiratory care • Inpatient medications • Lab and radiology services • Dressings, equipment, and other necessary supplies • Delivery, post-partum, newborn care • Blood or blood products Charges for rental of telephones, radios or televisions, or for guest meals or other personal items, are not covered. We cover services by any approved hospital that is owned and operated by the State of Oregon and any state approved community mental health and developmental disabilities program.	Updated language.

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Inpatient habilitative services page 44	As medically necessary to help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. The services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician.	Is covered if medically necessary to help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. The services must be consistent with the condition being treated and must be part of a formal written treatment program prescribed by a physician. This is covered with a maximum of 30 days per calendar year. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)	Updated language.
Inpatient rehabilitative services page 45	As medically necessary to restore and improve lost body functions after illness or injury. The services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician.	As medically necessary to restore and improve lost body functions after illness or injury. The services must be consistent with the condition being treated and must be part of a formal written treatment program prescribed by a physician. This is covered with a maximum of 30 days per calendar year. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)	Updated language.
Mental Health: outpatient	Outpatient mental health services are covered the same as any other medical service. The Plan pays based on the allowed amount and the network status of the provider. Preauthorization for outpatient mental health services is not required in most cases; see the Prior Authorization list.		Removed.
Mental health and chemical dependency/substance abuse services page 46	This Plan covers medically necessary treatment of mental health conditions and chemical dependency/substance abuse. Refer to Benefit exclusions for more information on services not covered by this Plan. **Mental health: prior authorization and review requirements** – Samaritan Health Plans must prior authorize coverage of all inpatient and residential treatment. Only emergency admissions are covered without prior approval, and then Samaritan Health Plans must be notified within 48 hours, or as soon as reasonably possible. This Plan covers, but is not limited to, the following mental health services: • Assessment and evaluation in order to diagnose a mental disorder, or determine if a mental disorder exists • Treatment of mental illness or disorders which are subject to significant improvement through evidence-based therapeutics • Treatment provided in healthcare facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services • Treatment provided at a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited wilderness therapy program that has been licensed by the State of Oregon as residential treatment for mental health and addiction services **Samaritan Health Plans covers services and treatment for those mental health and chemical dependency/substance abuse diagnoses covered under the Mental Health Parity Act. Samaritan Health Plans is compliant with state and federal mental health parity.**	The plan covers medically necessary treatment of mental health conditions and chemical dependency/substance abuse. Refer to Benefit exclusions for more information on services not covered by this plan. This plan covers, but is not limited to, the following mental health and chemical dependency/substance abuse services: • Assessment and evaluation in order to diagnose a mental disorder, or determine if a mental disorder exists • Treatment of mental illness or disorders which are subject to significant improvement through evidence-based therapeutics • Treatment, other than for substance use or abuse, provided in healthcare facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Outpatient intensive services and programs, including partial hospitalization, for substance use or abuse is covered in-network only. • Treatment provided at a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited wilderness therapy program that has been licensed by the State of Oregon as residential treatment for mental health and addiction services **Samaritan Health Plans covers services and treatment for those mental health and chemical dependency/substance abuse diagnoses covered under the Mental Health and Addiction Equity Act of 2008. Samaritan Health Plans is compliant with state and federal mental health parity.**	Updated language and combined sections.

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Specialized surgical and radiological services page 49	The value base copay for these procedures and services are in addition to, potentially regular copayment, or coinsurance as applicable. See your Benefit Schedule for cost share information. The radiology tier is a cost group that requires plan members to pay a copay for each of the following diagnostic tests and imaging services: • MRIs • CT scans • PET scans • SPECT scans The procedures tier is a cost group that requires plan members to pay a copay for each of the following procedures: • Spine surgery for pain • Arthroscopies Shoulder surgery for Osteoarthritis	The value base copay for these procedures and services are in addition to, potentially regular copayment, or coinsurance as applicable. See your Benefit Schedule for cost share information. Specialized surgical services have in-network coverage ONLY. The radiology tier is a cost group that requires plan members to pay a copay for each of the following diagnostic tests and imaging services: • MRIs • CT scans • PET scans • SPECT scans The procedures tier is a cost group that requires plan members to pay a copay for each of the following procedures: • Spine surgery for pain • Arthroscopies • Shoulder surgery for Osteoarthritis	Updated language. Surgical services will be covered in-network only.
Transplant services page 51	This Plan covers medically necessary organ and tissue transplants. It also covers the medical and hospital expenses of the donor if the transplant recipient is insured by Samaritan Health Plans. Samaritan Health Plans pays up to $8,000 for donor expenses. Corneal transplants are covered and do not require an authorization. This Plan covers the following medically necessary organ and tissue transplants: • Kidney • Kidney-Pancreas (under certain conditions) • Pancreas • Heart • Heart-Lung • Lung • Liver • Corneal (no authorization required) • Bone marrow and peripheral blood stem cell • Bone marrow for aplastic anemia • Leukemia • Lymphoma • Severe combined immune-delivery disease or Wiskott-Aldrich Syndrome • Pediatric bowel This Plan only covers transplant of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Immunosuppressive drugs associated with covered transplants are covered. There are no exclusion periods for transplants. For detailed transplant information, please contact Samaritan Health Plans at 541-768-4550 or 1-800-832-4580.	The plan covers medically necessary organ and tissue transplants. Corneal transplants are covered and do not require prior authorization. This plan covers the following medically necessary organ and tissue transplants: • Kidney • Kidney-Pancreas (under certain conditions) • Pancreas • Heart • Heart-Lung • Lung • Liver • Corneal (no authorization required) • Bone marrow and peripheral blood stem cell • Bone marrow for aplastic anemia • Leukemia • Lymphoma • Severe combined immune-delivery disease or Wiskott-Aldrich Syndrome • Pediatric bowel This plan only covers transplant of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Immunosuppressive drugs associated with covered transplants are covered. There are no exclusion periods for transplants. For detailed transplant information, please contact Samaritan Health Plans at 541-768-4550 or 1-800-832-4580.	Updated language.
Transplants, out of network page 51	If transplant services are available through a contractual agreement with an in-network facility but are performed at an out-of-network facility, this Plan pays the lesser of 50% of the billed amount or	If transplant services are available through a contractual agreement with an in-network facility but are performed at an out-of-network facility, this plan pays the lesser of 50% of the billed amount or	Updated language.

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	$100,000. The balance is your responsibility and does not accumulate toward this Plan's out-of-pocket maximum. Services provided by out-of-network providers are paid according to the percentages shown on the Benefit Schedule for out-of-network providers.	$100,000. The balance is your responsibility and does not accumulate toward this plan's out-of-pocket maximum. Services provided by out-of-network providers are paid according to the percentages shown on the Benefit Schedule for out-of-network providers. Covered charges are paid in full less applicable copays, coinsurance and deductibles.	
Traumatic brain injury services page 51		The plan covers medically necessary therapy and services for the treatment of a traumatic brain injury.	Added.
Preventive Care Services/Women's Preventive Care Services/Reproductive Health Care Services page 52	Preventive care services and chronic disease management do not require copays or cost sharing when received by an in-network provider. Out-of-network services will have cost sharing applied. See your Benefit Schedule for cost share information. Health care reform preventative services requirements are developed through the guidelines provided by the US Preventative Services Task Force (USPSTF), Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention, and Health Resources and Services Administration (HRSA). Prior authorizations are not required for preventive benefits. If you have question(s) as to whether a service is preventive, please contact our Member Services Department at 541-768-4550 or 800-832-4580. You can also visit the websites below for more information. A and B list for preventive services: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Women's preventive services: http://www.hrsa.gov/womensguidelines/ The schedules provided for this preventive benefit section below are only recommendations and do not represent a full list. **Contraceptives** – We cover all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling at no cost to the member for all women with reproductive capacity, as prescribed by a provider. Contraceptives are covered for: • A three month period for the first dispensing • A twelve month period for subsequent dispensing of the same contraceptive regardless if the member was enrolled in the Plan at the time of the first dispensing **PKU testing** – We cover PKU testing to detect the presence of Phenylketonuria (PKU). This is recommended testing for newborns. If the test detects the presence of PKU, we cover the formulas determined to be medically necessary for the treatment of PKU. We cover necessary formulas for treatment under the DME benefit of this Plan. **Colorectal screenings** – We cover services for colorectal cancer screening that have been assigned either a grade A or grade B by the United States Preventive Services Task Force (USPSTF) for any individual at high risk, and as a part of the individual's routine preventive care. Screenings are provided at	Preventive care services and chronic disease management do not require copays or cost sharing when received by an in-network provider. Out-of-network services will have cost sharing applied. See your Benefit Schedule for cost share information. Health care reform preventative services requirements are developed through the guidelines provided by the US Preventative Services Task Force (USPSTF), Advisory Committee on Immunizations Practices of the Centers for Disease Control, and Health Resources and Services Administration (HRSA). Prior authorizations are not required for preventive benefits. If you have questions as to whether a service is preventive, please contact our Member Services Department at (541) 768-4550 or (800) 832-4580. You can also visit the website below for more information. A and B list for preventive services: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ The schedules provided for the preventive benefits below are only recommendations and do not represent a full list. **PKU testing** – We cover PKU testing to detect the presence of Phenylketonuria (PKU). This is recommended testing for newborns. If the test detects the presence of PKU, we cover the formulas determined to be medically necessary for the treatment of PKU. We cover necessary formulas for treatment under the DME benefit of this Plan. **Colorectal screenings** – We cover services for colorectal cancer screening that have been assigned either a grade A or grade B by the United States Preventive Services Task Force (USPSTF) for any individual at high risk, and as a part of the individual's routine preventive care. Screenings are provided at zero cost share to the member for preventive screenings. The USPSTF recommends screening for adults age 50 and older using: • Fecal occult blood testing • Colonoscopies, including removal of polyps • Sigmoidoscopy • Double contrast barium enemas We cover preventive colorectal screenings for individuals who are younger than 50 or require a screening any time prior to a 10 year interval and have been diagnosed by their provider as high risk for	Added and updated language. Preventive Care Services section split into 'Preventive Care Services', 'Women's Preventive Care Services', 'Reproductive Health Care Services'.

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	zero cost share to the member for preventive screenings. The USPSTF recommends screening for adults age 50 and older using: • Fecal occult blood testing • Colonoscopies, including removal of polyps • Sigmoidoscopy • Double contrast barium enemas We cover preventive colorectal screenings for individuals who are younger than 50 or require a screening any time prior to a 10 year interval, and have been diagnosed by their provider as high risk for colorectal cancer. An individual is considered high risk if the individual has: • A family history of colorectal cancer • A prior occurrence of cancer or precursor neoplastic polyps • A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease • Crohn's disease or ulcerative colitis • Other predisposing factors **Immunizations** – We cover immunizations recommended by the Center for Disease Control and Prevention, as medically necessary. Covered expenses do not include immunizations for the sole purpose of travel, school, work/ occupation, or residence in a foreign country. Human papilloma virus (HPV) vaccine is covered for beneficiaries of this Plan who are at least 11 years of age but no older than 26 years of age. See Benefit exclusions. **Prostate screening exams** – Each calendar year for men age 50 and over or for those considered high risk. **Routine physical exams** – Routine physical exams can include related lab and radiology services, and bone density screening for patients considered at risk per Medicare guidelines. **Well child care** – Is covered. Recommendations are for 12 well baby exams in the first 36 months of life, then annually after that. **Well baby care** – Well-baby care covers physical examinations provided by a professional provider, including the standard in-hospital examination at birth, diagnostic X-rays, and laboratory services for an enrolled baby up to age 24 months. **Well child care** – We cover routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered. We cover physical examinations and any related laboratory tests and X-ray examinations up to the following amounts: • Age 2-6, one examination every benefit year • Age 7-17, one examination every two benefit years	colorectal cancer. An individual is considered high risk if the individual has: • A family history of colorectal cancer • A prior occurrence of cancer or precursor neoplastic polyps • A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease • Crohn's disease or ulcerative colitis • Other predisposing factors **Immunizations** – We cover immunizations recommended by the Centers for Disease Control and Prevention, as medically necessary. Covered expenses do not include immunizations for the sole purpose of travel, school, work/ occupation, or residence in a foreign country. Human papilloma virus (HPV) vaccine is covered for beneficiaries of this plan who are at least 11 years of age but no older than 26 years of age. See Benefit exclusions. **Prostate screening exams** – Each calendar year for men age 50 and over or for those considered high risk. **Routine physical exams** – Routine physical exams can include related lab and radiology services, and bone density screening for patients considered at risk per Medicare guidelines. **Well child care** – Is covered. Recommendations are for 12 well baby exams in the first 36 months of life, then annually after that. **Well baby care** – Well-baby care covers physical examinations provided by a professional provider, including the standard in-hospital examination at birth, diagnostic X-rays, and laboratory services for an enrolled baby up to age 24 months. **Well child care** – We cover routine periodic health appraisals, routing physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered. We cover physical examinations and any related laboratory tests and X-ray examinations up to the following amounts: • Age 2-6, one examination every benefit year. • Age 7-17, one examination every two benefit years. **Women's Preventive Care Services** We cover women's preventive care services. This includes annual women's exams, although it is recognized that several visits can be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. Women's exams include the following: **Clinical breast exam** – An annual breast exam for women 18 years of age or older or at any time when the women's healthcare provider recommends for the	

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	Women's exams – Annual women's exams are covered, although it is recognized that several visits can be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. Women's exams include the following: • **Clinical breast exam** – An annual breast exam for women 18 years of age or older or at any time when the women's healthcare provider recommends for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer. • **Routine gynecological exams** – Routine pelvic exams and Pap smears are covered. The USPSTF recommends screening for cervical cancer in women ages 18 to 64 years with cytology (Pap smear) every 3 years or when the women's health care provider recommends an exam. HRSA recommends HPV DNA testing for women age 30 and older with normal cytology to occur no more frequently than every 3 years. **Routine preventive mammograms** – An annual mammogram for the purpose of early detection for a woman 40 years of age or older is covered.	purpose of checking for lumps and other changes for early detection and prevention of breast cancer. **Routine gynecological exams** – Routine pelvic exams and Pap smears are covered. The USPSTF recommends screening for cervical cancer in women ages 18 to 64 years with cytology (Pap smear) every 3 years or when the women's health care provider recommends an exam. HRSA recommends HPV DNA testing for women age 30 and older with normal cytology to occur no more frequently than every 3 years. **Routine preventive mammograms** – An annual mammogram for the purpose of early detection for a woman 40 years of age or older is covered. We also cover screening and appropriate counseling or interventions for: • Breastfeeding comprehensive support, counseling and supplies; and • Breast cancer chemoprevention counseling. Women's preventive care services do not require copays or cost sharing when received by an in-network provider. Out-of-network services will have cost sharing applied unless: • There is no in-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time as defined by the Department of Consumer and Business Services by rule; or • An in-network provider is unable or unwilling to provide the service in a timely manner. See your Benefit Schedule for cost share information. Women's preventative services requirements are developed through the guidelines provided by the Health Resources and Services Administration (HRSA) and the Women's Preventive Services Initiative (WPSI). Prior authorizations are not required for women's preventive care benefits. If you have questions as to whether a women's care service is preventive, please contact our Member Services Department at (541) 768-4550 or (800) 832-4580. You can also visit the website below for more information. Women's preventive services: https://www.hrsa.gov/womens-guidelines/index.html **Reproductive Health Care Services** We cover reproductive health care services as required under the Oregon Insurance Code. Reproductive health services do not require copays or cost sharing when received by an in-network provider. Out-of-network services will have cost sharing applied. See your Benefit Schedule for cost share information. If you have questions as to whether a service is a reproductive health care service, please contact our Member Services Department at (541) 768-4550 or (800) 832-4580.	

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		The schedules provided for the reproductive health care services benefits below are only recommendations and do not represent a full list. **Contraceptives** – We cover all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling at no cost to the member for all women with reproductive capacity, as prescribed by a provider. Contraceptives are covered for: • a three month period for the first dispensing • a twelve month period for subsequent dispensing of the same contraceptive regardless if the member was enrolled in the Plan at the time of the first dispensing We also cover: • hormonal contraceptives, including oral, patches and rings, prescribed by a provider or pharmacist; and • pharmacy claims for over-the-counter contraceptives that are FDA approved. **Abortions** – Abortions are covered as required by state law. **Counseling** – We cover counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome. **Screening and counseling** – We cover screening for chlamydia, gonorrhea, Hepatitis B, Hepatitis C, human immunodeficiency virus and acquired immune deficiency syndrome, human papillomavirus, syphilis, anemia, urinary tract infection, pregnancy, Rh incompatibility, gestational diabetes, osteoporosis, breast cancer and cervical cancer. **We also cover:** • Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated; and • Screening and appropriate counseling or interventions for: • Tobacco use; and • Domestic and interpersonal violence	
Least Costly Setting for Services page 57	Covered services must be performed in the least costly setting where they can be provided safely. For example, if a procedure that can be done safely on an outpatient basis is done in a hospital inpatient setting, this Plan will only pay what it would have paid for the procedure on an outpatient basis.	Covered services must be performed in the least costly setting where they can be provided safely. For example, if a procedure that can be done safely on an outpatient basis is done in a hospital inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis. This determination will be made by Samaritan Health Plans.	Updated language.
Benefit Exclusions page 57		Alternative care treatment or services, except as outlined in the Samaritan Alternative Care Rider when purchased by the Plan Sponsor	Removed as this benefit is not part of the medical plan.
Benefit Exclusions page 58	Non-prescription drugs: Drugs, which by law do not require a prescription order, except for insulin, and certain over-the-counter (OTC) drugs specifically covered by this Prescription Drug coverage. Those medications considered OTC may be covered by the	Non-prescription drugs: Drugs, which by law do not require a prescription order, except for: o Insulin; o Certain over-the-counter (OTC) drugs specifically covered by the plan's	Added language.

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	Plan and require a written prescription from a physician.	prescription drug coverage for which a written prescription has been written by a physician; and o OTC contraceptives approved by the FDA	
Prior Authorization page 61	Coverage of certain medical services, medical drugs, and surgical procedures requires Samaritan Health Plans' written authorization before the services are performed. Your provider can request prior authorization by phone, fax, or mail. If for any reason your provider will not or does not request prior authorization for you, you must contact the Plan yourself. In some cases, additional information or a second opinion can be required before authorizing coverage. **Prior authorization by Samaritan Health Plans is required for the following medical services, medical drugs, and surgical procedures.**	Coverage of certain medical services and surgical procedures requires the written prior authorization of Samaritan Health Plans before the services are performed. Your provider can request prior authorization by phone, fax, or mail. If for any reason your provider will not or does not request prior authorization for you, you must contact Samaritan Health Plans yourself. In some cases, additional information or a second opinion can be required before authorizing coverage. Prior authorization by Samaritan Health Plans is required for the medical services, surgical procedures, and medical drugs listed on the website at **www.samhealthplans.org/employergroup.** Emergency Services will not require prior authorization. We request notification of any emergency admissions and observation stays which are not previously described in this plan document, which exceed 48 hours in order to ensure that all of the member's care is appropriately coordinated.	Updated language. Prior Authorization list has been removed from the certificate and will be available on the website.
Claims involving prior authorization (pre-service claims) page 61	**For services that do not involve urgent medical conditions** – Samaritan Health Plans will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Samaritan Health Plans will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Samaritan Health Plans will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied.	**For services that do not involve urgent medical conditions** – Samaritan Health Plans will notify your provider or you of its decision within two business days after the prior authorization request is received. If additional information is needed to process the request, Samaritan Health Plans will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Samaritan Health Plans will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, we will make a decision based on the information we have within 15 days following the 45 day period.	Updated language.
Length of Time Determinations are Valid page 62	A preauthorization benefit determination relating to benefit coverage and medical necessity is valid for 90 calendar days. A preauthorization benefit determination relating to the member's eligibility is valid for five working days, unless Samaritan Health Plans has specific knowledge that the member's coverage is ending within 90 calendar days. These specified times are not binding on Samaritan Health Plans if there was misrepresentation on the part of the policyholder, member, or provider that was relevant to the preauthorization request, or the request is incomplete.	A prior authorization benefit determination relating to benefit coverage and medical necessity of a mental or mental health service to be provided to a member is valid for 30 calendar days. A prior authorization benefit determination relating to the member's eligibility for coverage under the plan is valid for five business days, unless Samaritan Health Plans has specific knowledge that the member's coverage is sooner than five business days and Samaritan Health Plans specifies the termination date in the authorization. These specified times are not binding on Samaritan Health Plans if there was misrepresentation on the part of the policyholder, member, or provider that was relevant to the prior authorization request, or the request is incomplete. The prior authorization is limited to the specific provider requesting the authorization or to services of a designated group of in-network providers.	Updated language.
Other Services page 63		**Care Coordination Services** Samaritan Health Plans offers care coordination services to members who have been diagnosed with chronic medical conditions or who are experiencing complex medical events. Care coordination staff help members navigate and participate in their individual plan of care and support communication between providers across different healthcare settings. Care coordination services can include health coaching,	New section.

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		case management, and care management by the involved provider team. **Health Coaching** Samaritan Health Plans offers one-on-one services are designed to assist members in reaching health and wellness goals. The program will help you: • Identify what is motivating you to make lifestyle changes, • Set specific, measurable, attainable, realistic and time-limited goals, • Identify barriers and create steps to overcome the barriers, • Build skills to find reliable health information and wellness resources specific to your needs. **Plan Support Programs** We have the capability to develop support programs to compliment the medical advice of your healthcare provider. **Primary Care Home** The primary care home (PCH) practice provides relationship-based, primary health care that focuses on the health needs of the whole person. The PCH is responsible for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. They coordinate care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services. The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs. Come see us at 2300 NW Walnut Blvd. or contact us at: 541-768-4550, toll free 800-832-4580 or TTY 1-800-735-2900. Our Member Services Department hours are 8 a.m. to 8 p.m., Monday through Friday. We look forward to serving you.	
Explanation of Benefits (EOB)	We will report to you the action we take on a claim on a form called an Explanation of Benefits. If we deny all or part of a claim, the reason for our action will be stated on the Explanation of Benefits. The EOB will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your or your covered dependent's 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. 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		Removed.

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	made in good faith under this provision will fully discharge Samaritan Health Plans' obligations under the Plan.		
Payee of Claims page 64		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.	Added.
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.
Payment of Claims	Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate.		Removed.
Timely Submission of Claims	Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon Insurance Division's administrative rule setting standards for prompt payment. **Please send all claims to:** Samaritan Health Plans P.O. Box 887 Corvallis, OR 97339		Removed.
Claim Forms		Upon receipt of a notice of claim, we will furnish to the claimant such forms as are usually furnished 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 this certificate for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.	Removed.
Medicare page 70	In certain situations, this Plan is primary to Medicare. When you are covered by Medicare and this policy at the same time, we pay 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 your employer group health plan • When you or your covered dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan • When you or your covered dependent is entitled to benefits under section 226(b) of the social Security Act (Medicare disability) and by law	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)	Updated language.

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<tr><td></td><td>Medicare is secondary to your employer group health plan
For additional information on how this Plan coordinates with Medicare, please see www.medicare.gov.</td><td>and by law Medicare is secondary to the plan.
For additional information on how this plan coordinates with Medicare, please see www.medicare.gov.</td><td></td></tr>
<tr><td>Coordination page 71</td><td>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 dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits. The order of benefit determination rules listed on page 51 determine whether this Plan is a Primary plan or Secondary plan when a member has health care coverage under more than one plan.
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 may reduce the benefits we pay so that all Plan benefits do not exceed 100% of the total Allowable cost.</td><td>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 expense.</td><td>Updated section name and updated language.</td></tr>
<tr><td>Filing a Grievance page 77</td><td>Adverse Benefit Determination means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:
• Denial of eligibility for or termination of enrollment in a health benefit 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 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:
1. In writing, for internal appeal or an external review
2. 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, the employer group, or Plan Sponsor, and Samaritan Health Plans</td><td>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.
You may receive information about our grievance and appeal processes from 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</td><td>Definitions moved to 'Definitions' section. Updated language.</td></tr>
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	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.		
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 Benefit Plan Document 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		Removed.

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	• 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 your 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 if the insurer's adverse benefit determination is upheld on appeal • Other dispute options, such as mediation. One way to find out what may 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 • Results of all publically available accreditations surveys • Annual summary of the insurer's health promotion and diseases prevention activities • Annual summary of scope of network and accessibility of services		

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Compliance with State and Federal Mandates page 86	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 1976; The Americans with Disabilities Act of 1990; Executive Order 11246; the Age Discrimination in Employment Act of 1967; 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.
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.
Group Contract Renewal and Termination page 87	The Group contract will renew automatically from year to year unless terminated as otherwise provided in the Group contract. Samaritan Health Plans will only terminate the contract in the event of nonpayment of premiums, fraud, violation of participation or contribution rules, termination of the Plan, an employer moves outside the service area, or membership in the Association ceases. Termination of the member under the Group 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, which provides coverage for hospital or medical services or expenses under the provisions of the policy for those who have been hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer.	The Group Policy governing will renew automatically from year to year unless terminated by the employer as otherwise provided in the group contract. Samaritan Health Plans will only terminate the Group Policy in the event of nonpayment of premiums, fraud, violation of participation or contribution rules, termination of the plan, the employer moves outside the service area, or membership in an association ceases. Termination of the employer under the contract will completely end all obligations of Samaritan Health Plans to provide the members with benefits after the date of termination (**except where required by ORS 743B.341** which provides coverage for hospital or medical services or expenses under the provisions of a policy for those who have been hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer). 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.	Updated language.
Termination of Group	Samaritan Health Plans must receive written notice of termination from the Plan Sponsor. Samaritan Health Plans must receive the notice at least 30 days in advance of the proposed termination date. The Plan Sponsor must provide in writing whether Samaritan Health Plans is being replaced by another group policy. The Plan Sponsor shall continue to be liable for Samaritan Health Plans premiums for all members enrolled in Samaritan Health Plans through the Plan Sponsor until the agreed upon termination date.		Removed.
Legal Action page 88	No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after	No action at law or in equity shall be brought to recover on this plan prior to the expiration of 60 days after	Updated language.

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	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. 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. 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. 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.	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 employer are not fraudulent unless they are made with intent to knowingly defraud. In order for Samaritan Health Plans to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the employer, we must show that the misinformation is material to the content of this contract, that we relied upon the misinformation and that the information was either material to the risk assumed by us or that the misinformation was provided fraudulently. No claim for loss incurred or disability, as defined in the Certificate, commencing after two years from the date of issue of this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the Group Policy.	
Relationship to Samaritan Health Services page 88	The group on behalf of itself and its covered participants hereby expressly acknowledges its understanding that this Plan constitutes a plan solely between the employer group and Samaritan Health Plans. Neither Samaritan Health Plans, nor Samaritan Health Services is acting as the Plan Administrator or Plan Sponsor. 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. 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.	The employer on behalf of itself and its covered employees and their dependents hereby expressly acknowledges its understanding that this plan constitutes a plan solely between the employer group and Samaritan Health Plans. Neither Samaritan Health Plans, nor Samaritan Health Services is acting as the Plan Administrator or Plan Sponsor under ERISA. The employer on behalf of itself and its covered participants further acknowledges and agrees that it has not entered into this Plan based upon representations by any person or entity other than Samaritan Health Plans and that no person or entity other than Samaritan Health Plans shall be held accountable or liable to the employer or the members for any of our obligations to the employer or the members created under this Plan. This paragraph shall not create any additional obligations whatsoever on the part of Samaritan Health Plans other than those obligations created under other provisions of this plan.	Updated language.
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		Removed.

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	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.		
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.
Important Notices		**Notice of Special Enrollment** Under federal law, upon the incurrence of a "special enrollment" event, you have the right to enroll a dependent in the group health plan, and possibly yourself, during the middle of the year, without regard to the plan's normal annual open enrollment period rules. These special enrollment events are discussed below. **Loss of coverage.** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). **New dependent.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. **Medicaid or CHIP coverage.** If you or your dependents lose coverage under either a Medicaid plan or under a state child health insurance plan (CHIP) due to a loss of eligibility for that program's coverage, you may be able to enroll yourself and your dependents in this plan. You may also be able to enroll yourself and your dependents in this plan if you or your dependents become eligible for premium assistance for this plan through either a Medicaid plan or a state child health insurance plan (CHIP). For these two special enrollment options only, you must request enrollment within 60 days after the loss of eligibility or becoming eligible for premium assistance, as applicable. To request special enrollment or obtain more information, please contact your employer. **Women's Health and Cancer Rights Act** The Women's Health and Cancer Rights Act (WHCRA) of 1998 requires Samaritan Health Plans to notify you of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be	Added.

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		provided in a manner determined in consultation with your attending physician for: All stages of reconstruction of the breast on which the mastectomy was performed Surgery and reconstruction of the other breast to produce a symmetrical appearance Prostheses and treatment of physical complications of the mastectomy including lymphedema All stages of reconstruction are covered with a single determination of prior authorization. These benefits are subject to the plan's regular deductible and copays/coinsurance. See your Benefit Schedule for details.	
Certificate of Creditable Coverage	A covered person who ceases to be covered under the Plan will be provided a certificate that evidences the covered person's creditable coverage and the period of that creditable coverage. The time as of which the certificate will be provided and the contents of the certificate are explained below. **Creditable Coverage** is defined 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.		Removed.