

Samaritan Choice Plans

# 2011 NOTICE OF REQUIRED DISCLOSURES

This document provides changes to required disclosures for your Medical & Pharmacy Benefits Effective January 1, 2011

**KEEP THIS NOTICE WITH YOUR 2010 SAMARITAN CHOICE PLANS' MEDICAL & PHARMACY AND VISION PLAN DOCUMENTS. THIS IS A LEGAL PART OF YOUR PLAN DOCUMENTS.**

Please read this notice carefully and keep it where you can find it. This notice has important information about changes to your Medical & Pharmacy and Vision Plan Documents. All plan documents are available online at [www.samhealth.org/healthplans/members/samaritanchoiceplans](http://www.samhealth.org/healthplans/members/samaritanchoiceplans). You may request a copy of any plan document by contacting Samaritan Health Plans Customer Service at (541) 768-4550 or toll-free 1-800-832-4580 (TTY 1-800-735-2900), Monday through Friday, from 8 a.m. to 5 p.m.

# 2011 Samaritan Choice Plans Disclosures

The following are Federal laws and plan notices that apply to your health benefits coverage and are found in appropriate sections of your 2011 Plan Documents. You may access your plan document online at [www.samhealth.org/healthplans/members/samaritanchoiceplans](http://www.samhealth.org/healthplans/members/samaritanchoiceplans)

## 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 31 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 31 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, or
- 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.**

## Family and Medical Leave Act of 1993 (FMLA)

Employees are eligible for leave if they have at least 12 months of service and have worked at least 1,250 hours during the previous 12-month period. Eligible employees are entitled to request a FMLA leave for up to a maximum of 12 work-weeks within a 12-month period for the following reasons:

- to care for a child following a birth or placement of a child with the employee for adoption or foster care;
- to care for the spouse, child or parent of the employee who has a serious health condition; or
- if the employee is unable to perform the essential functions of his or her own job because of the employee's own serious health condition.

If both parents work for the Employer, they are entitled to a total of 12 weeks of leave for the birth of a newborn or the placement of an adopted or foster child, and they may decide how to divide the leave. An entitled family and medical leave (FMLA) is NOT considered a COBRA (see Continuation Coverage section) qualifying event unless coverage is reinstated at the end of the leave.

If the employee chooses to continue coverage while on an approved FMLA leave, he or she may do so by paying any required contribution rates that would have been paid by payroll deduction if they had been working. All contributions are due the first of each month, and if the employee fails to pay any required contribution, coverage will terminate on the last day of the month that contributions were paid.

If the employee returns to active employment after an entitled FMLA leave, group coverage will be reinstated. Waiting periods satisfied prior to an employee's approved leave would be reinstated when an employee returns to work. This is true even if coverage was terminated due to lapse of contribution payments on the employee's part. Benefits will be restored to the benefits equivalent to those the employee would have had if leave had not been taken and contribution payments had not been missed.

If the employee chooses not to participate while on an FMLA leave, but subsequently returns to active working status on or before the expiration of the leave, the employee and all Eligible Dependents will immediately become covered under the Plan without being required to give evidence of insurability.

If the employee fails to return from leave (except because of your own or a relative's serious health condition, or another circumstance beyond your control), SHS has the right to recover contributions it paid during the leave. If the employee does not return from a FMLA leave, health coverage will cease and a COBRA qualifying event will occur on the earlier of the:

1. end of the leave period, OR
2. day the Employer learns the employee does not plan to return.

Also, Oregon has a family leave law that has been revised to substantially parallel the federal FMLA law. However, there are a few provisions that differ between the Oregon Leave law and FMLA. Please contact the Human Resources office for details on the policies and procedures of these laws and to obtain the required leave request forms.

## Uniformed Services Employment and Reemployment Rights Act (USERRA)

Coverage will terminate if you are called to active duty by any of the armed forces of the United States of America. However, coverage can be continued for up to 18 months or the period of uniformed service leave, whichever is shortest, if you request to continue coverage and pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day you return to active employment with the group if you are released under honorable conditions, but only if you return to active employment:

- on the first full business day following completion of your military service for a leave of 30 days or less;
- within 14 days of completing your military service for a leave of 31 to 180 days; or
- within 90 days of completing your military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. There will be no additional deductible owed for the year as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer).

**Leave of absence.** If you are granted an approved non-FMLA or USERRA leave of absence, you can arrange to continue coverage for yourself and your family for up to three months. You must continue any premium contribution payments you were making prior to the leave.

## Strike or lockout

If you are covered by a collective bargaining agreement and are involved in a strike or lockout, coverage for you and your family may be able to be continued. You must pay the full cost of coverage directly to the union or organization that represents you.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Eligible employees and dependents are allowed coverage under the Samaritan Choice Plan when the employee, spouse, domestic partner, or dependent's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility, or the employee or dependent becomes eligible for a premium assistance subsidy under the Medicaid or Children's Health Insurance Program (CHIP). **To request special enrollment or to obtain more information, please contact your designated Human Resources department.**

## MICHELLE's Law (P.L. 110-381)

Effective January 1, 2010, eligible dependents are allowed to continue coverage under a Health Plan when a medically necessary change to part time student status or leave of absence from a post secondary educational institution is required. Please refer to the following guideline and definitions.

A **dependent child** is, a beneficiary under the plan who:

1. Is a dependent child, under the terms of the plan, of a participant or beneficiary under the plan; and,
2. Was enrolled in the plan, on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.

A medically necessary leave of absence in connection with a group health plan, is a leave of absence of the dependent child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:

1. commences while such child is suffering from a serious illness or injury;
2. is medically necessary; and
3. causes such child to lose student status for purposes of coverage under the terms of the plan.

Samaritan Choice Plans will not terminate coverage of a dependent child under the plan due to a medically necessary leave of absence before the date that is the earlier of:

- the date that is one (1) year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan.

To qualify for this exception the medically necessary leave of absence or change to part time student status will need to be certified by a physician as follows:

A written certification by a treating physician, of the dependent child, which states that the child is suffering from a serious illness or injury, and that the leave of absence (or other change of enrollment) described is medically necessary must be provided to Human Resources. To obtain more information please contact your designated Human Resources Department.

## Genetic Information Non-Discrimination Act of 2008 (H.R. 493 [110th])

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

## WHCRA full annual notice

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

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

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

Keep this notice for your records and call your Plan Administrator, Samaritan Choice Plans, for more information.

## **NEW:** The Newborns' and Mothers' Health Protection Act of 1996

Under federal law, this Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery (less than 96 hours following a caesarean section), or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

## **NEW:** Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26 (Section 2719A, Patient Protection and Affordable Care Act of 2010 (PPACA))

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll with Samaritan Choice Plans. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to Samaritan Choice Plans on January 1, 2011. For more information contact Samaritan Choice Plans administrators at (541) 768-4550 or 1-800-832-4580.

## **NEW:** Lifetime Limit and Enrollment Opportunity Notice (PPACA, 2010)

The lifetime limit on the dollar value of benefits under Samaritan Choice Plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Samaritan Choice Plans administrators at (541) 768-4550 or 1-800-832-4580.

## **NEW:** Patient Protections Notice (PPACA, 2010)

Samaritan Choice Plans generally allows the designation of a primary care provider\*. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Samaritan Choice Plans administrators at (541) 768-4550 or 1-800-832-4580.

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

You do not need prior authorization from Samaritan Choice Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Samaritan Choice Plans administrators at (541) 768-4550 or 1-800-832-4580.

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

## Statement of ERISA Rights

As a participant in this welfare benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Receive information about your plan and benefits

- Examine, without charge at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

## Continue group health plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage if applicable.

## Prudent actions by plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce your rights

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor,

or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with your questions**

**This document provides only essential guidance as required by Federal Guidelines and may not include all rules and requirements.** If you have any questions about your Plan, you should

contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



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