

Samaritan Choice Plans

2011 SUMMARY OF MATERIAL MODIFICATIONS

This document provides a list of changes to your Medical, Pharmacy and Vision 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. 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.

Medical and pharmacy benefit highlights for 2011

The following changes will apply to Samaritan Choice Standard Plan and Samaritan Choice High-Deductible Plan

Gastric By-Pass Criteria (page 31 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

- *Change:* The age criteria is changed from age 25 to age 18.
- *Addition:* Laparoscopic vertical sleeve gastrectomy is covered when authorized.

Pharmacy Plan Benefit Decisions (pages 27-28 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

- *Update:* Allow for a 90-day transition period on selected non-formulary Mental Health and behavioral drugs.
- *Update:* The medications listed in the formulary are subject to change. The presence of a medication in the formulary does not guarantee that you as a plan member will be prescribed that drug by your primary care physician or contracting provider for a particular medical condition. The medications may be subject to Prior Authorization. As new generics become available, the corresponding brand name drug will no longer be considered a preferred agent.

Mental Health Residential Annual Limit Maximum (page 27 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

Change: The 14-day annual maximum is removed from the plan in accordance to Mental Health Parity Act.

Lifetime Maximum (pages 4 and 7 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

Change: The lifetime maximum set for \$2,000,000 per member in 2010 is removed from the plan as of January 1, 2011. This is not to be confused with any annual maximum benefits as maximums still apply. See the Plan Summary for more details.

Dependent Children Age Limits (page 12 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

Addition: The full time student status is eliminated as a requirement under the plan. The age limit for dependent children is increased through the age of 25. Plan provisions on Disabled Dependent benefits remain unchanged.

Acupuncture Services(pages 6 and 9 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

Change: The reimbursement for out of network services is changing from 70% to 65%. The in network benefit will remain unchanged

Prior Authorization (page 38 of 2010 Samaritan Choice Plans Medical & Pharmacy Benefits):

Addition: Mohs Micrographic Surgery has been added to the list of elective procedures that require a Prior Authorization effective January 1, 2011.

The following medical benefit changes will apply to Samaritan Choice Standard Plan only

NOTE: Refer to benefit tables, beginning on page 3 of this document

The 2011 Samaritan Choice Standard Plan medical benefit changes include new tiers (cost groups). For 2011, there will be four new tiers:

1. Education and Coaching
2. Preventative
3. Care Management
4. Value-Based Cost

New types of office visits

In addition to the Preventative Tier that allows preventative services without a co-pay, Samaritan Choice introduces an *Education and Coaching* tier and a *Care Management* tier.

These new cost groups give Samaritan Choice Plan members a lower co-payment for office visits related to education about a condition or questions for one of the following diseases:

- Congestive heart failure
- Coronary artery disease
- Diabetes
- Chronic obstructive pulmonary disease
- Asthma

With the addition of *Education and Coaching* and *Care Management* tiers, there are now five different types of office visits:

- Preventative
- Education and Coaching
- Care Management
- Primary care
- Specialist care

Why is there a new lower co-payment for office visits for education and coaching?

Making tools and information available to Samaritan Choice Plan members to help prevent and predict chronic conditions is important to us. These include tools that address general lifestyle factors, physical, social and psychological health factors.

Self-care is an important factor in staying healthy. Giving employees tools to help them manage their own health and resources to reach out for help is the key to a healthy lifestyle.

By making your co-payment lower for the office visits related to your ongoing wellness needs, the new *Education and Coaching* cost group makes these office visits more affordable and encourages you to seek information and education on how to stay healthy.

The new lower co-payment for *Education and Coaching* applies only to office visits to a Samaritan-provider.

Beginning on January 1, 2011: Your office visits for wellness education and coaching will have a lower co-payment as long as your office visit is with an "in-network" Samaritan provider.

If your office visit for one of these medical conditions is with an "out-of-network" provider, then you will not have the new lower co-payment. If you want to change from an out-of-network provider to an in-network provider, you can go to your medical plan's website and use the provider directory to search for in-network providers.

Why is there a new lower co-payment for office visits for certain ongoing medical conditions?

If you have an ongoing medical condition such as asthma, a heart condition, high cholesterol, high blood pressure, or diabetes, then you

know it is especially important to look after your health. This includes making regular visits to your doctor. Staying on schedule with these visits helps to make sure you are getting all the tests and other care you need to stay healthy. Seeing your doctor regularly helps to prevent complications by finding problems at an early stage when treatment can be more effective.

By making your co-payment lower for the office visits related to your ongoing medical condition, the new *Care Management* tier makes these office visits more affordable and encourages you to stay on schedule with your regular medical care.

The new *Care Management* tier applies only to office visits to an in-network provider.

Beginning on January 1, 2011: Your office visits for congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma will have a lower co-payment (*Care Management* Tier) as long as your office visit is with an in-network provider.

If your office visit for one of these medical conditions is with an out-of-network provider, then you will not have the new lower co-payment. If you want to change from an out-of-network provider to an in-network provider, you can go to your medical plan's website and use the provider directory to search for in-network providers.

The new Value-Based Cost tier adds a \$500 co-pay for certain procedures

The Value-Based Cost tier is a new cost group that requires plan members to pay a \$500 co-pay for each of the following procedures:

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

The \$500 co-pay for these *Value-Based Cost* procedures is in addition to a member's plan deductible, regular co-payment, or coinsurance as applicable. The \$500 co-pay does not count toward the member's yearly out-of-pocket maximum.

Why is there a new value-based co-payment for these procedures?

For the procedures on Value-Based Cost tier, the value-based co-payment is to encourage plan members to talk with their doctor and consider other choices before deciding whether to have the procedure.

For each procedure on the Value-Based Cost tier, there are other possible treatment choices to consider that might be less invasive, safer, and work just as well or better, depending on the patient's situation. A different treatment choice may also be more cost-effective than the Value-Based Cost tier procedure.

What if one of these procedures is recommended for you?

If one of the Value-Based Cost procedures is recommended for you, ask your doctor to explain why you need the procedure, what would happen if you decided not to have it, and what other treatment choices you could consider.

Your doctor can help you understand and compare the risks, benefits, and costs of the Value-Based Cost procedure and your other treatment choices. You may also want to get a second opinion from another doctor.

If you and your doctor decide that one of the Value-Based Cost procedures is right for you, you will have to pay the \$500 value-based co-pay when you have the procedure. There is only one exception: the \$500 value-based co-pay is not required if the procedure is related to a service given as a result of a visit to the emergency room.

Value-based co-payment for tests and certain services

A value-based \$200 co-pay for certain tests and services

A value-based \$200 co-pay will be required for each of the following diagnostic tests and imaging services:

- MRIs
- CT scans
- PET scans

The new \$200 co-pay for these tests and services must be paid in addition to a member's plan deductible, regular co-payment, or coinsurance as applicable. The value-based \$200 co-pay does not count toward the member's yearly out-of-pocket maximum.

Why is there a new value-based co-payment for these tests and services?

For, MRIs, CT scans, and PET scans, the value-based \$200 co-pay was added to encourage plan members to talk with their doctor and consider other choices before deciding whether or not to have the test or imaging service.

What if one of the tests and services with value-based \$200 co-pay has been recommended for you?

If an, MRI, CT scan, or PET scan has been recommended for you, ask your doctor to explain why you need it, what would happen if you decided not to have it, and what other choices you could consider.

Your doctor can help you understand and compare the risks, benefits, and costs of the test or service that has been recommended with the other choices you may have. You may also want to get a second opinion from another doctor.

If you and your doctor decide that one of the diagnostic tests or imaging services with the value-based \$200 co-pay is right for you, then you will have to pay the \$200 Value-based co-payment when you get the test or service. There is only one exception: the value-based \$200 co-pay is not required if the procedure is related to a service given as a result of a visit to the emergency room.

The co-pays for "Value-based" procedures, tests, and services only apply to in network services.

The co-pays for the Value-based procedures, tests, and services apply to in network services only. Out of network services will apply to the deductible and will reimburse at the out of network rate.

(If you want to change from an out-of-network provider to an in-network provider, you can go to your medical plan's website and use the provider directory to search for in-network providers.

↓ ↓ ↓ **THIS SECTION REPLACES THE BENEFIT TABLES ON PAGES 5 - 9 IN SAMARITAN CHOICE PLANS 2010**
MEDICAL & PHARMACY BENEFITS ↓ ↓ ↓

2011 Summary of Benefits

The tables below summarize the 2011 Benefits for the Samaritan Choice Standard and High-Deductible Plans. Please refer to your plan document for a detailed description of your benefits. **Important Notice: All services apply to the deductible unless otherwise specified.**

Samaritan Choice Standard Plan

Service	2011 PREFERRED (In Network)	2011 Non-Preferred (Out of Network)
PREVENTIVE SERVICES (these services are not applied to your deductible & some services will not have a cost share)		
Well baby care	100%	70%
Routine physicals	100%	70%
Routine gynecological exams	100%	70%
Immunizations	100%	70%
Colonoscopy	100%	70%
PROFESSIONAL SERVICES		
Primary care visits ¹	100% after \$20 co-pay	70%
Specialist visits	100% after \$35 co-pay	70%
Urgent care center visits	100% after \$20 co-pay	100% after \$20 co-pay
Surgery professional (at hospital)	100% after \$50 co-pay	70%
CARE MANAGEMENT SERVICES – In-Network Only (For: Asthma, Diabetes, Coronary Heart Failure, Coronary Artery Disease, Coronary Obstructive Pulmonary Disease)		
Office visit	100%	70%
EDUCATION & COACHING SERVICES (For specific services provided by SHS Providers only (GSRMC, SLCH, SAGH, SPCH and SNLH). Regular cost-sharing is assessed for any other provider.		
Office Visit for specified Wellness and Education services ⁶	100%	70%
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	100% after \$100/day co-pay, up to 5 days or \$500	70%
Inpatient rehabilitative care	100% after \$100/day co-pay, up to 5 days or \$500	70%
Skilled nursing facility care	100%	70%
Bariatric surgery/ gastric banding (Lap band) surgery ²	100% after \$5000 co-pay	Not Covered
OUTPATIENT SERVICES		
Outpatient surgery	100% after \$150 co-pay	70%
Emergency department visits (unless admitted to hospital)	100% after \$100 co-pay	100% after \$100 co-pay
Diagnostic and therapeutic radiology and lab	100%	70%
VALUE-BASED COST SERVICES – In-Network only(Specified Surgical Procedures & High Tech Imaging)		
Specified Surgical Procedures (Spine surgery for pain, Arthroscopies, Shoulder surgery for Osteoarthritis)	\$500 co-pay ^{3,4} (Does not apply to member OOP ⁵ maximum)	70%
High Tech Imaging Services (CT scans, MRIs and PET scans)	\$200 co-pay ^{3,4} (Does not apply to member OOP ⁵ maximum)	70%

Samaritan Choice Standard Plan

Service	2011 PREFERRED (In Network)	2011 Non-Preferred (Out of Network)
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Office Visits	100% after \$35 co-pay	70%
Inpatient Care	100% after \$100/day co-pay, up to 5 days or \$500	70%
Residential Programs	70%	70%
OTHER COVERED SERVICES		
Physical and Occupational Therapy	100% after \$25 co-pay (Combined limit/calendar year: \$2,900)	70% (Combined limit/calendar year: \$2,900)
Speech Therapy	100% after \$25.00 co-pay (Up to \$2,900 limit/calendar year)	70% (Up to \$2,900 limit/calendar year)
Allergy Injections(Most) ⁶	100% after \$5 co-pay	70%
Injectibles and Other Drugs Administered Other than Orally (When rendered in the office) ⁶	90%	90%
Ambulance, Ground	70% after \$100 co-pay	70% after \$100 co-pay
Ambulance, Air	70%	70%
Durable Medical Equipment	70%	50%
Home Health Care	100% after \$15 co-pay	70%
Hospice	100%	70%
Hearing Aids	Up to \$700 limit/year	Up to \$700 limit/year
Acupuncture	100% after \$35 co-pay	65%
Panniculectomy ⁷	50%	Not Covered

¹Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.

²Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit.

³Co-pay does not apply if coded as Emergency Services. Cost shares will default to normal benefit for Emergency Services.

⁴These Value-based co-pays do not count towards annual deductibles and Out-of-Pocket Limits. Regular co-payment or coinsurance must be separately paid as applicable.

⁵OOP: Out- Of –Pocket Maximum or Limit.

⁶Contact Customer Services at (541) -768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance levels and applicable services.

⁷Panniculectomy coinsurance does not apply to Out-Of- Pocket Limit. Services will only be covered when gastric bypass has been rendered by contracted provider.

Samaritan Choice High Deductible Plan

Services	2011 PREFERRED (In Network)	2011 Non-Preferred (Out of Network)
PREVENTIVE SERVICES (These services are not applied to your deductible & some services will not have a cost share)		
Well Baby Care	100%	70%
Routine Physicals	100%	70%
Routine Gynecological Exams	100%	70%
Immunizations	100%	70%
Colonoscopy	100%	70%
PROFESSIONAL SERVICES		
Primary Care Visits ¹	100% after \$20 co-pay	70%
Specialist Visits	100% after \$35 co-pay	70%
Urgent Care Center Visits	100% after \$20 co-pay	100% after \$20 co-pay
Surgery Professional (at hospital)	100% after \$50 co-pay	70%

Samaritan Choice High Deductible Plan

Services	2011 PREFERRED (In Network)	2011 Non-Preferred (Out of Network)
HOSPITAL / INPATIENT SERVICES		
Inpatient Room and Board	100% after \$100/day co-pay, up to 5 days or \$500	70%
Inpatient Rehabilitative Care	100% after \$100/day co-pay, up to 5 days or \$500	70%
Skilled Nursing Facility Care	100%	70%
Bariatric Surgery/ Gastric banding (Lap band) surgery ²	100% after \$5000 co-pay	Not Covered
OUTPATIENT SERVICES		
Outpatient Surgery	100% after \$150 co-pay	70%
Diagnostic and Therapeutic Radiology & Lab	100%	70%
CT, PET Scans	100%	70%
MRIs	100% after \$150 co-pay	70%
Emergency department visits (unless admitted to hospital)	100% after \$100 co-pay	100% after \$100 co-pay
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Office Visits	100% after \$35 co-pay	70%
Inpatient Care	100% after \$100/day co-pay, up to 5 days or \$500	70%
Residential Programs	70%	70%
OTHER COVERED SERVICES		
Physical and Occupational Therapy	100% after \$25 co-pay (Combined limit/calendar year: \$2,900)	70% (Combined limit/calendar year: \$2,900)
Speech Therapy	100% after \$25.00 co-pay (Up to \$2,900 limit/calendar year)	70% (Up to \$2,900 limit/calendar year)
Allergy Injections(<i>Most</i>) ³	100% after \$ 5 co-pay	70%
Injectibles and Other Drugs Administered Other than Orally (When rendered in the office) ³	90%	90%
Ambulance, Ground	70% after \$100 co-pay	70% after \$100 co-pay
Ambulance, Air	70%	70%
Durable Medical Equipment	70%	50%
Home Health care	100% after \$15 co-pay	70%
Hospice	100%	70%
Hearing Aids	Up to \$700 limit/year	Up to \$700 limit/year
Acupuncture	100% after \$35 co-pay	65%
Panniculectomy ⁴	50%	Not Covered

¹Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.

²Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit.

³Contact Customer Services at (541) - 768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance level

⁴Panniculectomy coinsurance does not apply to Out-Of- Pocket Limit. Services will only be covered when gastric bypass has been rendered by contracted provider.

↓ ↓ ↓ **THIS SECTION REPLACES OUT-OF-POCKET COST TABLES ON PAGE 4 & PAGE 7 IN SAMARITAN CHOICE PLANS' 2010 MEDICAL & PHARMACY BENEFITS** ↓ ↓ ↓

2011 Deductibles and Maximum Lifetime Benefit

Annual out-of-pocket limits remain unchanged:

Samaritan Choice Standard Plan

- Preferred Providers: \$2,000 per person or \$6,000 per family/ calendar year.
- Non-Preferred Providers: \$15,000 per person or no limit per family/ calendar year.

Samaritan Choice High Deductible Plan

- Preferred Providers: \$3,500 per person or \$10,500 per family/ calendar year.
- Non-Preferred Providers: \$17,500 per person or no limit per family/ calendar year.

Pharmacy benefit has a separate out-of-pocket limit of \$2,000 per person/calendar year for both plan options. There are no family out-of-pocket limits for this benefit.

Annual Individual and Family Deductibles remain unchanged.

Samaritan Choice Standard Plan	Preferred Providers	Non-Preferred Providers
Annual Individual Deductible	\$200	\$200
Annual Family Deductible	\$600	\$600
Maximum Lifetime Benefit	\$2,000,000 in 2010; Removed in 2011	

Samaritan Choice High-Deductible Plan	Preferred Providers	Non-Preferred Providers
Annual Individual Deductible	\$2500	\$2500
Annual Family Deductible	\$7500	\$7500
Maximum Lifetime Benefit	\$2,000,000 in 2010; Removed in 2011	

↓ ↓ ↓ **THIS SECTION REPLACES THE BENEFIT TABLE ON PAGE 10 IN SAMARITAN CHOICE PLANS' 2010 MEDICAL & PHARMACY BENEFITS** ↓ ↓ ↓

2011 Prescription drug benefits

Therapeutic	Preferred Generic	Preferred	Non-Preferred	High-Cost Injectibles
\$0 for: <ul style="list-style-type: none"> • 7 specified generic drugs • Selected Asthma medications • Tobacco Cessation drugs/supplies 	\$7 or 20% whichever is greater	\$25 or 25% whichever is greater	50%	10%

↓ ↓ ↓ **THIS SECTION REPLACES PAGE 47 IN SAMARITAN CHOICE PLANS' 2010 MEDICAL & PHARMACY BENEFITS** ↓ ↓ ↓

Member grievances and appeals process

Authorized representative

You or someone you name to act on your behalf (Authorized Representative) may file a verbal or a written grievance and/ or appeal in writing with Samaritan Choice Plan (SCP).

Your Authorized Representative can be a relative, friend, advocate, attorney, doctor, or someone else who is already authorized under State law.

Please note that in order for SCP to process a request received from your Authorized Representative, we must have proof of such designation; such as, a signed representative form; other appropriate legal papers supporting an authorized representative's status or a Durable Power of Attorney document.

SCP has an Authorized Representative form that you can request by calling our Customer Service Department at (541) 768-4550 or toll free at 1-800-832-4580 or TTY/TTD 1-800-735-2900.

Filing a grievance

Grievance means a verbal or written complaint regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the Plan through a prior authorization; or
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between the member and the Plan.

You have the **option** to file a grievance (complaint) through Samaritan Choice Plan's Dissatisfaction Resolution Team or you may choose to move straight to the appeal process without submitting a grievance.

Upon receiving a grievance, we will send you or your Authorized Representative an acknowledgment letter. If the grievance cannot be resolved within five business days of receipt, we will notify you in writing that additional time is required. You or your Authorized Representative will then receive a written decision within 30 days from your initial call or letter.

If you remain dissatisfied with the outcome of your grievance, you or your Authorized Representative may file a written appeal within 180 days of the denial or other action, giving rise to the grievance.

Filing an internal appeal

If you remain dissatisfied after the initial adverse benefit decision or grievance decision, you or your Authorized Representative have the right to file an appeal. The appeal request must be: 1) in writing, 2) signed, 3) include the appeal reason; and 4) received by us within 180 days of the denial or other action giving rise to the grievance. You may use an [Appeal Request Form](#) to provide this information. Within five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter.

The Internal appeal decision will be determined by an appropriate healthcare professional not previously involved in your case. You or your Authorized Representative have the right to appear in person to talk about your appeal.

During the Internal review, we may require an extension for processing your pre-service appeal. If so, a letter will be sent to you explaining the circumstances requiring the extension and a description of any additional information needed from you or your providers. In no event will this extension exceed the time frames explained in the **Appeal Timelines** section. If you do not agree with our decision to extend the timeframe to process your appeal, you may file a grievance.

You or your Authorized Representative will receive a written decision within 30 days (pre-service, plus extension if needed) or 60 days (post-service) of our receiving your appeal request.

PLEASE NOTE: If you, your Authorized Representative or your treating provider believes that the request to appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, your appeal will be processed in an expedited manner (72 hours of our receiving the appeal). Only pre-service requests qualify for expedited processing.

You, your Authorized Representative or your treating provider may request a simultaneous expedited External Review.

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

External review

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

- The Plan does not adhere to the rules and guidelines of the process defined for the Internal review;

OR

- The Internal review has been completed; and, the reason for the adverse decision was:

- based on medical necessity; or,
- for treatment determined to be experimental or investigational; or,
- for the purpose of continuity of care

OR

- You and the Plan have mutually agreed to waive the internal appeal requirement.

Your request for an External Review must be received in writing to us within 120 days of our final adverse determination. Within five business days of receiving your request for External Review, we will send you or your Authorized Representative a confirmation letter that your request is eligible for External Review. (If your request is not eligible for External Review, the Plan will notify you or your Authorized Representative in writing and include the reasons for the ineligibility.)

To apply for an External Review you must send your written request or the Appeal Request Form to us at the following address:

Samaritan Choice Plans Appeal Department
P.O. Box 336
Corvallis, Oregon 97330-0336

External Review decisions are made by randomly assigned Independent Review Organizations (IRO) who are not associated with Samaritan Health Services.

Please Note: When you request an External Review, the Plan will send you or your Authorized Representative a waiver that allows the IRO access to your medical records pertaining to the Internal Appeal adverse decision. It is important for you to know that the Plan can only continue to process your request if the signed waiver is returned.

The Plan, upon receiving notification of the assigned IRO, will forward your request within 5 business days. You will receive a letter from the IRO informing you that your request for External Review has been received. You will have 10 business days to submit additional information directly to the IRO.

The IRO will return a written decision to you or your Authorized Representative and to the Plan within the following timeframes:

- Expedited External Review - 72 hours after receipt of the request
- Standard External Review - 45 days after receipt of the request

IRO decisions are final and we are bound by their decisions. If you want more information regarding External Review, please contact our Customer Service Department at (541) 768-4550; toll-free at 800-832-4580 or TTY 1-800-735-2900.

Expedited appeals

If you believe your appeal is urgent, you, your Authorized Representative or your treating provider, may request an Expedited appeal. If the appeal request meets the definition of urgent; meaning, a decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, the appeal will be processed in an expedited manner (within 72 hours of our receiving the appeal request).

For urgent appeals your treating provider may act as your Authorized Representative without a signed Authorized Representative form.

If the appeal does not meet the definition of urgent, you will be notified immediately and the appeal will then be processed within the standard timeframe.

When applicable, you may **simultaneously** request an expedited External Review, in addition to an expedited Internal Review.

An expedited External Review may be filed verbally or in writing within 120 days of our Initial or Final adverse determination.

An expedited Internal Review may be filed verbally or in writing within 180 days after you receive notice of the initial adverse determination.

The Expedited appeal request must:

- be based on a pre-service adverse determination,
and
- state the reason for the appeal request;
and
- state the reason an expedited decision is needed;
and
- include supporting documentation necessary for the Plan to make a decision.

The Internal Expedited review decision will be determined by an appropriate healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative and your treating provider as soon as possible but no later than 72 hours of our receiving the appeal. A written notice will be mailed within one working day following the verbal notification.

For an expedited External Review, the randomly assigned IRO will have 72 hours to make their decision from the time they receive the appeal information from the Plan.

To apply for an Internal or External expedited review, send your written request or the Appeal Request Form to:

Samaritan Choice Plans Appeal Department
P.O. Box 336
Corvallis, Oregon 97330-0336

Or call our Customer Service Department:

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

Appeal timelines

Samaritan Choice Plans (SCP) adheres to the following timeframes for making decisions for an internal appeal:

- 72 hours for urgent
- 30 days for pre-service
- 60 days for post-service

SCP may take an extension of up to 14 days, in addition to the above timeframes, for urgent and pre-service appeals. You will be notified in writing if an extension is necessary.

Forms:

You may obtain the following forms for your appeal by contacting our Customer Care Department at: (541) 768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900, OR online at:

www.samhealth.org/healthplans/members/samaritanchoiceplans

- Authorized Representative
- Appeal Request
- Authorization to Disclose Health Plan Records

Your appeal rights

You have the right to:

- File a grievance about and appeal any decision we make regarding availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the Plan through a prior authorization; claims payment, handling or reimbursement for healthcare services or matters pertaining to the contractual relationship between the member and the Plan.
- Contact us when you:
- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was not approved;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision.
- A full and fair internal review of your appeal by individuals associated with us, but who were not involved in the adverse decision.
- Provide us with additional information that relates to your appeal.
- Appear in person to talk about your internal appeal.
- An Internal review decision within 30 days for pre-service appeals, 60 days for post-service appeals and 72 hours for an expedited appeal.
- File an External Review (at no cost to you) if applicable.
- An External Review decision within 45 days of the IRO receiving your standard request and 72 hours for an expedited request.
- Send additional information, in writing, directly to the IRO.
- An Expedited review if you, your Authorized Representative or your treating provider believes that waiting the standard 30 day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed.
- A simultaneous Expedited Internal and External Review, if applicable.
- Information about our grievance and appeal processes, you may contact our Customer Care Department at (541) 768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900; or you can write to the following address:
Samaritan Choice Plan - Appeal Department
P.O. Box 336
Corvallis, OR 97339-0336
- File a complaint and seek assistance by contacting:
 - The Director of the Department of Consumer and Business Services (DCBS) at:
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
350 WINTER STREET NE
PO BOX 14480
SALEM, OR 97309-0405
 - Or email dcbs.director@state.or.us
 - The Department of Labor at:
U.S. Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Ave., N.W.
Washington, D.C. 20210



Samaritan Choice Plans
Samaritan Health Plans Operations
815 NW Ninth Street, Suite 101
Corvallis, Oregon
www.samhealth.org/healthplans/members/samaritanchoiceplans