

Samaritan Choice Plans

# VISION BENEFITS

Your Samaritan Employee Health Plans  
2010 Plan Document

2010

## Introduction

This document describes the Vision Benefits for Samaritan Health Services employees and affiliated adopting employers. It serves as both the Plan Document and the Summary Plan Description and is designed to explain your Plan as of January 1, 2010.

Every effort has been made to make these explanations as accurate as possible. For more information, contact Samaritan Choice Plans at (541) 768-4550 or 1-800-832-4580.

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This is your 2010 Samaritan Choice Vision Plan Document

# TABLE OF CONTENTS

<b>Definitions</b> .....	<b>1</b>	<b>Grievances and appeals</b> .....	<b>23</b>
<b>2010 Samaritan Choice vision plan benefits</b> .....	<b>4</b>	Resolving a dispute or complaint .....	23
Covered benefits .....	4	Appealing a decision.....	23
Limitations and exclusions .....	4	Appeal timelines.....	23
<b>Service area and out-of-area services</b> .....	<b>5</b>	<b>Your member rights and responsibilities</b> .....	<b>24</b>
<b>Who is eligible</b> .....	<b>6</b>	Your RIGHTS as a member: .....	24
<b>How and when to enroll</b> .....	<b>8</b>	Your RESPONSIBILITIES as a member:.....	24
<b>What happens if eligibility changes?</b> .....	<b>10</b>	<b>Certificate of creditable coverage</b> .....	<b>25</b>
Family and Medical Leave Act of 1993 (FMLA) .....	10	Rights to receive certificates .....	25
Uniformed Services Employment and Reemployment Rights Act (USERRA) .	11	Automatic provision of certificate .....	25
Strike or Lockout.....	12	Provision of certificate upon request.....	25
Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) .	12	Specification of benefits .....	25
MICHELLE’s Law (P.L. 110-381) .....	12	<b>Claims information</b> .....	<b>26</b>
<b>Continuation coverage</b> .....	<b>13</b>	<b>HIPAA privacy notice</b> .....	<b>27</b>
<b>General provisions</b> .....	<b>16</b>	<b>Statement of ERISA Rights</b> .....	<b>28</b>
Medical necessity of continuing care .....	16	<b>Plan administration</b> .....	<b>30</b>
Quality of medical care .....	16	Other authorities and responsibilities .....	30
Third-party liability and right of subrogation.....	16	Compliance with State and Federal mandates.....	30
Motor vehicle accidents.....	17	<b>Summary plan description</b> .....	<b>31</b>
Coordination of benefits .....	17	General Information .....	32
<b>Circumstances causing ineligibility or loss of benefits</b> .....	<b>22</b>	<b>Customer service</b> .....	<b>33</b>



# Definitions

**Allowed amount.** This is the amount that is payable to the provider of service for medically necessary, covered services. This amount is the combination of the Samaritan Choice Plans payment and any deductible, coinsurance, or co-payment owed by the member. Amounts allocated to deductible, coinsurance, or co-payments are so indicated by the Explanation of Benefits. Contracted Providers must write off, or not charge, the Samaritan Choice Plans patient for balances other than the deductible, coinsurance, or co-payment. Providers may collect from members for services that are not covered benefits under the Samaritan Choice Plans policy.

**Annual enrollment.** A period of time each year (usually the month of December) when eligible employees who did not enroll themselves or their eligible dependents within their initial 31-day eligibility period can enroll in the Plan.

**Benefit year.** The period of time starting on the date coverage begins and ending 12 months after that.

**Calendar year.** The period of time starting on January 1st and ending on December 31st each year.

**Coinsurance.** This is the amount of the benefits for which a member is responsible. Coinsurance is defined as a percentage of the Allowed Amount. It applies after the deductible and any applicable co-pays have been met.

**Coordination of benefits.** A method for determining the amount that each plan should pay when a Covered Person is covered under two or more health care plans. It determines which plan is primary, paying its normal benefits, and which plan is secondary, paying the balance of the expense up to the limit for that plan.

**Co-payment.** A co-payment or co-pay is a flat fee in place of or before the application of coinsurance. Members are responsible for co-payments regardless of the presence of any deductible. Co-payments and/or Coinsurance are not applied toward the deductible, including preventive service co-

payments/coinsurance. Members are responsible for payment of co-pays at the time of service.

**Cosmetic surgery.** Designed to improve a person's appearance without improving function.

**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.

**Deductible.** This is the portion of covered benefit costs each member is obligated to pay before Samaritan Choice Plans will provide benefits.

**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.

**Employer.** Samaritan Health Services and any other affiliated entity that adopts the Plan. Participants and beneficiaries may receive from the Plan Administrator, upon written request, a complete list of affiliated entities adopting the plan

**Incur.** The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the Covered Person receives it.

**Injury.** A personal bodily injury to a Covered Person caused solely by external, violent, and accidental means and resulting directly or indirectly of all other causes in an Eligible Expense.

**Maximum plan allowance.** The amount on which Samaritan Choice Plans will base its reimbursement to physicians and providers. The maximum amount is no less than the seventy-fifth (75th) percentile of fees commonly charged for a given procedure in a given area, based on the Ingenix MDR system, a national database. If this database does not contain a fee for a particular procedure in a particular area, the claim is referred to our Medical

Consultant who determines a comparable code to the one billed. Samaritan Choice Plans will use the Maximum Plan Allowance for the comparable code to price the claim.

**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 true 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

**Medically necessary.** Medically necessary means health care services or supplies that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

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

**Participating providers.** A licensed vision provider who has agreed to render services in accordance with terms and conditions established by Samaritan Choice Plans and has satisfied Samaritan Choice Plans that he or she is in compliance with such terms and conditions.

**Plan.** Samaritan Choice Plans, which is described in this Plan Document.

**Plan document.** Written legal description of the Plan.

**Preferred provider or facility.** A provider or facility that has an effective Preferred Provider Plan contract with Samaritan Choice Plans to provide services and supplies to the covered individuals under this plan

**Professional services.** Services of a professional medical provider for medically necessary diagnosis or treatment of illness or injury, and for preventive care services.

**Professional provider.** Licensed or Registered Medical Providers that provide Medically Necessary covered services within the scope of their license or registry. The term "Professional Provider" does not include a naturopath, an acupuncturist, or any other class of provider not covered by the Plan.

**USERRA.** USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations promulgated thereto.

**Usual, customary and reasonable (UCR) charges.** Medical expenses are covered at the percentage stated in the Summary of Benefits for the covered services a Covered Person receives based on Usual, Customary and Reasonable charges as defined:

- *Usual* – The fee charged for a given service by an individual or institutional provider. That is the provider’s own “usual” fee.
- *Customary* – A fee is customary if it is in the range of usual fees charged by providers of similar training and experience in a similar area.
- *Reasonable* – A fee is reasonable if it is both usual and customary, or in the opinion of the Claims Administrator, it is justifiable considering the special circumstances of the case in question.

Samaritan Choice Plans members may be responsible for UCR charges if services are provided by a non-preferred provider.

# 2010 Samaritan Choice vision plan benefits

This Plan pays for vision examinations, and corrective lenses and frames when prescribed by a licensed ophthalmologist or licensed optometrist, for you and your insured dependents. The Plan allows you to choose any licensed ophthalmologist, optician, or optometrist. However, for eye examinations, there is a difference in reimbursement for participating vision providers and non-participating vision providers.

There is **no deductible** for covered vision services or supplies and the benefits are paid at 100% of the allowed charge, up to the limits listed below, for services at participating vision providers (70% for services at non-participating vision providers). Allowed charge means the charge for covered services up to the maximum plan allowance. These vision care benefits are provided on a calendar year basis.

## Covered benefits

**Eye Examinations:** One complete eye exam (including eye refraction exam), per calendar year; covered 100% after a \$25 co-pay for participating vision providers and 70% after a \$25 co-pay for non-participating vision providers.

**Vision Hardware and/or Accessories:** The following hardware and/or accessories are covered on a calendar year basis at a combined benefit maximum limit of \$250 per calendar year:

- Single Vision Lenses
- Polycarbonate Lenses and Tinting #1 & # 2
- Bifocal Lenses
- Trifocal Lenses
- Contacts
- Frames

## Limitations and exclusions

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

### Exclusions

The following are not covered benefits under this Plan:

- Visual field charting;
- Fitting fees for lenses or eye glasses
- Orthoptics or vision training;
- Lenticular lenses;
- Contact lenses, except as shown in the Schedule
- Subnormal vision aids;
- Aniseikonic lenses;
- Tinted lenses, except no. 1 and no. 2 pink;
- Nonprescription lenses; or
- More than the allowance for a standard prescription when multi-focal hard resin lenses, coated lenses or no-line bifocals (blended type) are chosen;
- Extra charges for fashion eyewear features such as blended, coated, flintglass, oversize lenses or extra charges for special frames
- Medical or surgical treatment of the eyes;
- Services and supplies that are payable under a workers' compensation or occupational disease law;
- Any expense which results from an act of declared or undeclared war or armed aggression;
- Any expense which is in excess of the maximum plan allowance;
- Any eye examination required as a condition of employment; and
- Any expense paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the Policyholder.

## Service area and out-of-area services

The Samaritan Choice Plans Service Area is defined as Linn, Benton and Lincoln Counties.

If you or any members of your family live outside the Plan's Service Area, you may not have the option of receiving services from a preferred provider.

If a change in residence occurs, contact Samaritan Choice Plans right away to discuss options for continuing coverage under this plan.

Not all providers in our service area are considered to be a preferred provider.  
Please call Customer Service to verify the Network status of your provider before obtaining services  
at (541) 768-4550 or 1-800-832-4580.

# Who is eligible

**Employees.** All non-temporary employees of SHS who are regularly scheduled to work at least 20 hours per week are eligible under the Plan. Coverage begins the first day of the month following 30 days of employment.

Exceptions: 1) Wiley Creek Community (Senior Care Division) employees who are regularly scheduled to work at least an average of 20 hours per week are eligible for coverage under the Plan following completion of 6 months of employment. Coverage begins the first day of the month following 6 months of regular employment. 2) Class 1, 2, 3, and 9 employees are eligible for coverage under the Plan on the first day of the month following or coinciding with the first date of hire.

Workers classified by the Employer as independent contractors are not eligible to participate in the Plan during the period they are classified as independent contractors, even if those workers are later retroactively reclassified as employees.

**Family members.** While you are eligible and insured under this plan, the following family members are also eligible for coverage:

- Your lawful spouse as defined by the State of Oregon (except for legal separation).
- Any unmarried dependent children under age 24 who meet the student qualifications below.
- Any unmarried dependent children under age 24 who are students regularly attending school, community college, college or university, or regularly attending a course of professional or technical training designed to fit the child for gainful employment. Dependent children over age 18 and under age 24 must be full-time students to be eligible under this plan. A child enrolled in a course load of less than that determined by the educational facility to be “full-time” enrollment is not a “child attending school.”
- Any unmarried children over age 23 who are mentally disabled or physically handicapped, and who have been incapable of self-

sustaining employment since age 23. Samaritan Choice Plans may require proof of disability and periodic verification of this situation.

- Domestic partners of employees who have this benefit available through their place of employment and who meet all of the following criteria (*Contact your Human Resources Department for more information, or to see if you qualify.*):
  - The partner is 18 years of age or older,
  - The employee and the partner share a close personal relationship,
  - The employee and the partner are responsible for each other’s common welfare,
  - The employee and the partner share a permanent residence with the intent to continue doing so indefinitely,
  - The employee and the partner are jointly financially responsible for basic living expenses including, but not limited to, food, shelter, and medical expenses,
  - Neither the employee nor the partner is legally married to anyone else,
  - The employee and the partner have lived together as a domestic partnership and met all other criteria set forth in this section for at least six months, and
  - The employee and the partner are not related to each other by blood closer than would bar marriage in Oregon or the state where they have a permanent residence and are domiciled.
  - The employee and the partner are not eligible as dependent children on their parent’s plan if they are also eligible as domestic partners.

The Internal Revenue Service (IRS) does not recognize a domestic partner as being a qualified dependent except in very limited circumstances. Thus, under IRS rules, coverage of a domestic partner under the Plan is a taxable benefit to the employee. Accordingly, employees must pay income taxes on the fair market value of the Plan coverage provided to their domestic partners and the dependents of domestic partners. The value of the domestic partner coverage is considered wages, is included in the employee's gross income, and is subject to state and federal income tax and FICA withholding. However, any benefits paid for the domestic partner that are attributable to coverage included in the employee's income are taxable neither to the employee nor to the partner.

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.

QMCSO. Samaritan Choice Plans will extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA. Samaritan Choice 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 Customer Services Department.

For purposes of coverage under the Plan, the term "child" includes:

- a biological child of you or your spouse;
- an adopted child of you or your spouse;
- a child actually placed with you while adoption proceedings are pending;
- a child for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO)<sup>1</sup>;
- a child for whom you are legal guardian; and
- a child of a qualified domestic partner of an employee (see applicable IRS information above).

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.

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<sup>1</sup> You may obtain, without charge, a copy of our procedures governing QMCSO determinations by contacting our Member Services department at 1-800-832-4580 or (541)768-4550.

# How and when to enroll

**When you first become eligible.** Most SHS employees become eligible the first day of the month after they become non-temporary employees. In the Senior Care Divisions of SHS including, but not limited to, Wiley Creek Community, employees who are regularly scheduled to work at least 20 hours per week are eligible for coverage under the Plan following completion of 6 months of employment. Coverage begins the first day of the month following 6 months of regular employment.

During this waiting period, you should file with the Human Resources office an enrollment form for yourself and any eligible dependents you wish to have enrolled in the Plan. The Human Resources office must receive this application within 31 days after the date you become eligible for coverage in order for you and your eligible dependents to become covered as of the initial eligibility date. By enrolling, you are agreeing to participate and you are authorizing compensation reduction contributions to cover your share of the cost of your elected coverage under the Plan. Your Employer will announce your required contribution each year.

**Enrolling new dependents.** If you become married while you are covered under the Plan, your new spouse and his or her children become eligible for coverage on the date of the marriage. Your new stepchildren must meet the dependency or other eligibility requirements applicable to children as discussed earlier.

Your qualified domestic partner may enroll by submitting an enrollment application and completed Domestic Partnership Affidavit at the time of your initial enrollment or within 31 days of the partnership first becoming eligible according to the criteria stated in the Eligibility section. All other domestic partner applications will be subject to late enrollment provisions.

**Please note:** If you intend to have your newborn covered under the plan, it is imperative that you enroll your child as soon as possible. Please contact your designated Human Resources Department for assistance. The Plan covers your newborn child for 31 days after the child's birth if the child is not covered

under a different plan. An adopted child will be covered for 31 days from the time of placement with you for adoption if the child is not covered under a different plan. "Placement" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. If the child's placement for adoption does not become final, coverage for the child will end on the date the child is removed from placement.

To continue coverage for the newborn or adopted child beyond the first 31 days after the date of birth or placement for adoption, you must submit a new enrollment form to the Human Resources office within the 31-day period, listing the child as a new dependent. If this is not done, coverage for the newborn or adopted child will terminate at the end of the 31-day period.

**Waiver of coverage.** You may waive coverage under the Plan for yourself. You may also waive coverage for any of your eligible dependents. If you waive coverage for yourself, your dependents are not eligible for coverage. To waive coverage, you must file a *Declination of Coverage* form with the Human Resources office specifying the reason for the waiver. The form must list by name each of the dependents for whom you waive coverage.

**Subsequent enrollment.** If you do not enroll yourself and/or your eligible dependents within 31 days of first becoming eligible, you may be considered a "late enrollee." If so, you must wait until the next Annual Enrollment period (which is the month of December) to enroll. If you then enroll, coverage will become effective as of the following January 1.

**NOTE:** You and/or your eligible dependents will not be considered a "late enrollee" in the following circumstances:

- You did not enroll because you and/or your eligible dependents were covered under another health benefit plan (including benefits consisting of medical care under any hospital or medical services policy or HMO). However, you must state in writing that you do not want to enroll yourself (or a dependent) in the Plan due to other

coverage. If you subsequently lose that other coverage, you or your eligible dependents may enroll in the Plan within 31 days. In this situation, your effective date of coverage will be the first day following your loss of coverage under the other health benefit plan.

- A court has ordered that coverage be provided for your child under your health benefit plan and a request for enrollment is made within 31 days after issuance of the court order.
- You are newly eligible under Oregon's Family Health Insurance Assistance Program, FHIAP, and a request for enrollment is made within 31 days after issuance of FHIAP eligibility.

### **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 your 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:

- 1) The employee's, spouse, domestic partner, or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, or
- 2) 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.**

# What happens if eligibility changes?

A number of events, such as changes in your employment or marital status, may affect your eligibility for coverage under the Plan. This section explains what happens in these situations.

**Termination of employment.** 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). Refer to the Continuation Coverage section for details on the extended coverage.

**Transfer to casual 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 20 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 and your covered dependents may then be able to extend coverage on a self-pay basis. Refer to the Continuation Coverage section for details on the extended coverage.

**Legal annulment of marriage, legal separation or divorce.** Coverage for your spouse and any children who cease to meet the definition of eligible family members (for example, former stepchildren) normally ends on the last day of the month in which the final decree is entered. Your spouse and/or other former family members may be able to extend coverage on a self-pay basis. Refer to the Continuation Coverage section for details on the extended coverage.

**If your domestic partnership ends.** Coverage for your domestic partner and any children of a domestic partner (not related to the enrolled employee by birth or adoption) will terminate upon the death of the employee or termination of the domestic partnership, whichever comes first. The employee and partner are required by the domestic partnership affidavit to give written notice to the employer within 31 days of any change in qualifying criteria. Domestic partners

and their children may not continue this policy's coverage under the continuation provisions independent of the employee.

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

**If your children are no longer eligible.** Coverage normally ends on the last day of the month when your children are no longer eligible because they:

- marry, (or become a domestic partner for health plan coverage purposes)
- reach age 24, or
- reach age 19 and no longer meet the "child in school" criteria.

(Please also refer to section on Michelle's Laws P.L. 110-381 page 12 for additional information)

Your children may extend their coverage for up to 36 months on a self-pay basis. Refer to the Continuation Coverage section for details on the extended coverage.

## 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 workweeks 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:

- end of the leave period or
- 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:

- A. is a dependent child, under the terms of the plan, of a participant or beneficiary under the plan; and,

- B. 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:

- A. the date that is one (1) year after the first day of the medically necessary leave of absence; or
- B. 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.

# Continuation coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Federal law requires that most employers sponsoring group health plans offer employees and their family members the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you of your rights and obligations under the continuation coverage provisions of the law. **Both you and your spouse should take the time to read this section carefully.** Please contact your designated Human Resources department for more information.

This law has been amended from time to time. In the event of any conflict between this continuation of coverage provision and the current provisions of the law, the current provisions of the law shall govern. Your rights are described below.

As an employee of SHS, you may have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment, or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you may have the right to choose continuation coverage for yourself if you lose coverage under this Plan for **any** of the following reasons:

- The death of your spouse;
- A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
- The divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by this Plan, he or she may have the right to continuation coverage if group health coverage is lost for **any** of the following reasons:

- The death of a parent who is a covered employee;

- The termination of a parent’s hours of employment with the Employer;
- A Parent’s divorce or legal separation;
- A parent who is a covered employee becomes entitled to Medicare; or
- The dependent ceases to be a “dependent child” under this Plan.

Under this law, the employee or a family member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date the spouse or dependent would lose coverage because of one of these events.

When SHS is notified that one of these qualifying events has happened, you will, in turn, be notified that you may have the right to choose continuation coverage. Under the law, you must inform SHS that you want continuation coverage within 60 days of the later of:

- The date you would lose coverage because of one of the events described earlier; or
- The date on which you are sent notice of your right to elect continuation coverage.
- The American Recovery and Reinvestment Act allows former employees and beneficiaries who did not elect COBRA coverage during their regular COBRA election period, but are eligible for the COBRA subsidy, an additional 60 days to elect coverage following the receipt of the COBRA notice mailed by Human Resources. **Please contact your designated Human Resource department for more information.**

Anyone who is a Covered Person on the qualifying event date is a “Qualified Beneficiary” and has the individual right to elect continuation coverage. A Qualified Beneficiary can add a new spouse during the continuation period on the same terms as an active Employee. The newly added spouse is a beneficiary. A beneficiary cannot elect coverage that is different from that

elected by the Qualified Beneficiary. The beneficiary’s continuation period shall end on the same date that the Qualified Beneficiary’s continuation period ends.

If you do not choose continuation coverage, your group health insurance coverage will end as of the last day of the month in which occurred the event that gave rise to your continuation coverage rights (the “qualifying event”). If you choose continuation coverage, SHS is required to allow you to elect the health coverage that you were receiving immediately prior to the COBRA qualifying event. In all regards, you may elect to continue to receive (i) medical/pharmacy, dental and vision coverage, (ii) dental/vision coverage or (iii) medical coverage only.

The law requires that you and your covered dependents be given the opportunity to maintain continuation coverage for the continuation periods below:

<b>Qualifying Event</b>	<b>Maximum Continuation Period</b>
<b>Continuation Periods for Employee, Spouse and Dependent Children</b>	
Covered employee’s termination of employment	18 Months*
Covered employee’s reduction in work hours (for any reason) below those required to maintain normal coverage (e.g., less than 20 hours a week, certain leaves of absence)	18 Months*
<b>Continuation Periods for Spouse and Dependent Children</b>	
Covered employee’s divorce or legal separation	36 Months
Covered employee’s death	36 Months
Covered employee’s entitlement to Medicare benefits	36 Months
Dependent child’s loss of status as dependent child of the Covered employee under the terms of the Plan	36 Months

\*The original 18-month continuation period may be extended as follows:

- Up to an additional 18 months if another qualifying event occurs during the original continuation period (with a 36-month maximum continuation period).
- If you elected COBRA continuation coverage based on termination of employment or reduction of hours and you become disabled (as determined by Social Security) any time within the first 60 days of COBRA continuation coverage, the disabled individual and covered family members (who are also continuing coverage due to the same event) may be eligible for an 11-month coverage extension (at an increased cost), for a total of 29 months of COBRA continuation coverage. To elect the 11-month extension, you must notify SHS within 60 days of the date that Social Security determines that you or your family member is disabled and within the first 18 months of COBRA continuation coverage. Also, you must notify SHS within 30 days after any final determination that you or your family member are no longer disabled.
- For a spouse or dependent of a covered employee when the covered employee becomes entitled to Medicare benefits at the time of, or before a qualifying event, up to an additional 18 months after the covered employee becomes entitled to Medicare benefits.

However, the law also provides that a person’s continuation coverage will end earlier than above on the occurrence of the earliest of the following reasons:

- SHS no longer provides group health coverage to any of its employees;
- The person fails to pay his or her premium for continuation coverage on time;
- The person becomes covered under another group health plan (but see Preexisting condition limitation discussed below);
- The person becomes entitled to Medicare after electing continuing coverage under this plan; or
- The person is no longer determined to be disabled, if coverage is continued beyond the 18<sup>th</sup> month due to the person’s disability.

**Preexisting condition limitation.** COBRA continuation coverage will terminate when you become covered under another group health plan, but only if the other plan does not contain an exclusion or limitation that affects a preexisting condition you have. However, most health plans are required to credit time covered under a prior plan toward any preexisting condition coverage-waiting period. If you become covered under another group health plan having a preexisting condition coverage-waiting period that is satisfied due to this crediting of prior coverage, your COBRA continuation coverage may be terminated.

**Newborn and adopted children.** If you are entitled to COBRA because you are a current or former employee of SHS and a child is born or placed for adoption while you are on COBRA continuation coverage, you can enroll your new child for COBRA continuation coverage immediately. Your newborn and adopted child will obtain “qualified beneficiary” status. In other words, the child will have independent election rights and second qualifying event rights (i.e., same rules that apply to an active employee).

**Premium payments.** If you are eligible for continuation coverage, you do not have to show that you are insurable (proof of good health) to choose continuation coverage. However, under the law, you must pay 102% of the premium rate for your continuation coverage, unless you qualify for a COBRA subsidy under the American Recovery and Reinvestment Act (ARRA). The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your

COBRA continuation coverage. **Please contact your designated Human Resources department for more information.**

These rules apply to your spouse and dependents that are eligible for continuation coverage. Individuals receiving a disability extension may be charged 150% of the premium during the extension. Premiums must be mailed or delivered to your Human Resources office. Your first payment is due no later than 45 days after the date you elect continued coverage retroactive to the date coverage ceased. Payment for each subsequent month’s coverage is due on the first day of the month and must be received within 30 days of the due date. Required monthly premiums may change during the continuation period in the manner allowed by the law. The continuation applicant will be notified of any changes in the benefits and/or rates during the continuation period.

If you have any questions about the law, please contact your Human Resources office. Also, if you have changed marital status, or you or your spouse have changed addresses; please notify your Human Resources office immediately.

Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly. In the event that more than one continuation provision under the Plan applies to, the periods of continuous coverage will run concurrently to the extent permitted by law.

**Should you or a family member on COBRA coverage through Samaritan Choice Plans move out of our service area, please note, all non-emergent and non-PCP services shall be considered a preferred provider if provided through an out-of-area contracted provider or non-preferred if provided through a non-contracted provider.**

# General provisions

## Medical necessity of continuing care

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

## Quality of medical care

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

## Third-party liability and right of subrogation

If a Covered Person receives any benefits arising out of an Injury or Illness for which the Covered Person (or his or her guardian or estate) may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the Plan for such benefits shall be made on the condition and with the understanding that the Plan will be reimbursed. Such reimbursement will be made by the Covered Person (or his or her guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Covered Person (or his or her guardian or estate) from any policy or contract from any insurance company or carrier, including the Covered Person's insurer, or any third party, plan or fund as a result of a judgment, settlement, arbitration, award or other arrangement. The Covered Person on behalf of his or herself (or his or her guardian or estate) acknowledges and agrees that the Plan will be reimbursed in full before any amounts are deducted from the policy, proceeds, award, judgment, settlement or other arrangement. This obligation to reimburse the Plan shall be equally binding upon the Covered Person regardless of whether or not the third party or its insurer has admitted liability or the medical charges are itemized in the third party payment.

The Plan will not pay or be responsible, without its prior written consent, for any fees or costs associated with a Covered Person pursuing a claim against any coverage. Neither the "make-whole rule" nor the "common-fund doctrine" of insurance law applies under the Plan.

Any reimbursement required by this provision shall also apply when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

The Plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers, including the Covered Person's insurer. The amount of such subrogation will be equal to the total amount paid under the Plan arising out of the Injury or Illness for which the Covered Person (or his or her guardian or estate) has, may have or asserts a cause of action. In addition, the Plan will be subrogated for attorney fees incurred in enforcing its subrogation rights under this provision.

By reason of such subrogation, the Plan or the Claims Administrator on behalf of the Plan has the right to sue and assert rights against any such third party in a Covered Person's name.

If a Covered Person incurs expenses for treatment of the Injury or Illness after receiving a recovery, the Plan will not pay benefits for covered expenses until the total amount of the covered expenses incurred after the recovery exceeds the net recovery amount (i.e., the amount of the recovery minus the amount previously reimbursed to the Plan).

The Covered Person on behalf of himself or herself (or his or her guardian or estate) specifically agrees to do nothing to prejudice the Plan's rights to reimbursement or subrogation. In addition, the Covered Person on behalf of himself or herself (or his or her guardian or estate) agrees to cooperate fully with the Plan and Claims Administrator in asserting and protecting the Plan's subrogation rights. The Covered Person on behalf of himself or herself (or his or

her guardian or estate) agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the Plan's subrogation rights.

The Covered Person specifically agrees on behalf of himself or herself (or his or her guardian or estate) to notify the Claims Administrator, in writing, of whatever benefits are paid under the Plan that arise out of any Injury or Illness that provides or may provide the Plan subrogation rights under this provision.

Failure to comply with the requirements of this provision by the Covered Person (or his or her guardian or estate) may result in a forfeiture of benefits under the Plan.

## Motor vehicle accidents

Most motor vehicle liability policies are required to provide a full range of liability insurance that includes medical care. The Plan will not pay medical costs if the Covered Person is entitled to health care under motor vehicle insurance. It will pay benefits toward Eligible Expenses over the amount covered by the motor vehicle insurance. If the Covered Person is paid benefits before motor vehicle insurance payments are made, then the Plan is entitled to reimbursement from any subsequent motor vehicle insurance payments made to the Covered Person. The Plan may recover expenses directly from the motor vehicle insurer or from any settlement or judgment that the Covered Person obtained from a third party.

Before the Plan pays a benefit, the Covered Person must provide information about any motor vehicle insurance payments that may be available. Also, at the request of the Claims Administrator, the Covered Person must sign an agreement to hold the income of any recovery in trust for the Plan.

## Coordination of benefits

**1. Coordination of this group contract's benefits with other benefits.** This Coordination of Benefits (COB) section applies when a Covered Person has health care coverage under more than one plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each plan will pay a claim

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

**2. Definitions relating to coordination of benefits Plan.** Plan means any of the following that provides benefits or services for medical, pharmacy or routine vision services. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

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

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

Each contract for coverage listed under 2.1 and 2.2 above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

**The Plan.** The Plan means, as used in this COB section, the part of this contract to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from the Plan. A contract may 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 in Section 3 determine whether the Plan is a primary plan or secondary plan when a Covered Person has health care coverage under more than one plan.

When primary, Samaritan Choice Plans determines payment for our benefits first before those of any other plan without considering any other plan's benefits. When secondary, Samaritan Choice Plans determines our benefits after those of another plan and may reduce the benefits Samaritan Choice Plans pays so that all plan benefits do not exceed 100% of the total allowable expense.

**Allowable expense.** Allowable expense means a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any plan covering a Covered Person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a Covered Person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an allowable expense.

The following are examples of expenses that are NOT allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
2. If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4. If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because the Covered Person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

**Closed panel plan.** A closed panel plan is a plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that has contracted with or is employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

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

**3. Order of benefit determination rules.** When a Covered Person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.
- B.
  - 1) Except as provided in paragraph (2) below, a plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.
  - 2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- D. Each plan determines its order of benefits using the first of the following rules that apply. Rules are applied in a sequential order:
  - 1) Non-dependent or dependent. The plan that covers a member other than as a dependent, for example as an employee, subscriber or retiree is the primary plan and the plan that covers the member as a dependent is the secondary plan. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent; and primary to the Plan covering the member as other

than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the member as an employee, subscriber or retiree is the secondary plan and the other plan is the primary plan.

- 2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a member is a dependent child and is covered by more than one plan the order of benefits is determined as follows:
  - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
    - ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
  - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree;
    - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;

- iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or
  - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:
    - The plan covering the custodial parent, first;
    - The plan covering the spouse of the custodial parent, second;
    - The plan covering the non-custodial parent, third; and then
    - The plan covering the dependent spouse of the non-custodial parent, last.
  - c. For a dependent child covered under more than one plan of individuals who are not the parents of the dependent child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the dependent child.
- 3) **Active Employee or Retired or Laid-off Employee.** The plan that covers a member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same member as a retired or laid-off employee is the secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- 4) **COBRA or State Continuation Coverage.** If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, subscriber or retiree or covering the member as a dependent of an employee, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- 5) **Longer or Shorter Length of Coverage.** The plan that covered the member as an employee, subscriber or retiree longer is the primary plan and the plan that covered the member the shorter period of time is the secondary plan.
- 6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, The Plan will not pay more than Samaritan Choice Plans would have paid had Samaritan Choice Plans been the primary plan.
- 4. Effect on the benefits of this plan.** When the Plan is secondary, Samaritan Choice Plans may reduce our benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

**5. Right to receive and release needed information.** Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under The Plan and other plans.

Samaritan Choice Plans may get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under the Plan and other plans covering a member claiming benefits. Samaritan Choice Plans need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under this Plan must give Samaritan Choice Plans any facts we need to apply this section and determine benefits payable.

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

**7. Right of recovery.** If the amount of the payments made by Samaritan Choice Plans is more than we should have paid under this COB section, Samaritan Choice Plans may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## Coordination with Medicare

If you and/or your spouse are enrolled in Medicare and this Plan at the same time, this Plan will pay benefits first when:

- You or your covered spouse are age 65 or over and by law Medicare is secondary to this Plan;
- You or your covered spouse incur expenses for kidney transplant or kidney dialysis and by law Medicare is secondary to the Plan; or
- You are entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to the Plan.

Medicare is the primary payer for non-working persons and spouses of non-working persons who first become entitled to Medicare on the basis of age or disability prior to acquiring End Stage Renal Disease (ESRD) as specified by law.

## Circumstances causing ineligibility or loss of benefits

The Plan contains numerous conditions and limitations that may affect your or your family's right to participate or receive benefits. This section will highlight just a few such conditions and limitations. You or your family's rights may be affected by any of the following:

- Being employed by an employer that has not adopted the Plan (see "Who is eligible" on page 6).
- Not being or remaining an eligible employee (see "Who is eligible" on page 6).
- Not timely submitting an election to participate (see "How and when to enroll" on page 8).
- Failing timely to pay for continuation coverage (see "Continuation coverage" on page 13) or regular coverage while on FMLA leave (see "What happens if eligibility changes?" on page 10).
- Changing your employment status or family status (see "What happens if eligibility changes?" on page 10).
- Failing timely to submit claims for reimbursement (see "Claims information" on page 26 and "Grievances and appeals" on page 23).
- Being called to active duty by any of the Armed Forces of the United States (see "What happens if eligibility changes?" on page 10).
- Reaching a benefit maximum, including the Plan's lifetime maximum benefit (see "Limitations and Exclusions" on page 4 and elsewhere for other maximum limits).
- Failing to reimburse the Plan under its right of subrogation (see "General Provisions" on page 16).
- Being subject to a Plan amendment (see the "Summary Plan Description" on page 31).

# Grievances and appeals

## Resolving a dispute or complaint

This plan provides a grievance procedure for all members. If you believe a policy, action or decision of ours is incorrect, please contact our Member Service Department. If we cannot resolve your concern to your satisfaction, you (or an individual you authorize in writing to represent you in the grievance and appeal process) may file a written appeal with us within 180 days of the denial or other action, giving rise to the grievance. Failure to appeal within this time period will preclude all further rights to appeal and may jeopardize your right to contest the action in any forum.

If you have a complaint about any part of your treatment, follow these steps:

### Filing a Grievance:

1. Contact Samaritan Choice Plans in writing. Samaritan Choice Plans Customer Service will investigate and attempt to resolve the complaint.
2. The Plan's Medical Director or another designated health care professional will review complaints pertaining to any quality of care concern.

## Appealing a decision

**Appeal Level 1:** You may appeal by calling or writing to the Samaritan Choice Plans office listed on the denial letter or the Explanation Of Benefit (EOB). An SCP designee will review your appeal and any new documentation you provide. If the original decision is overturned, you will be informed verbally or in writing and the appropriate action (payment of claim, provision of authorization, etc.) will be taken. If the decision is upheld, your appeal will be forwarded to an internal blinded review. You will receive a written decision, which will include:

1. the specific reasons for the denial,
2. the specific reference to pertinent Plan provisions,

3. a description of any additional material or information needed from you to further support your appeal
4. information about filling a Level II appeal.

**Appeal Level 2:** If you are not satisfied with a decision regarding authorization or payment for services, and you have exhausted the Level One appeals process, a second level of review is available through an External Review source. You can request a second level appeal by writing to: Samaritan Choice Plans, PO Box 336, Corvallis, OR 97339-0336. You should provide relevant documentation to support your appeal within 60 days of the date of the appeals level 1 denial.

The Level II Appeal Review shall be conducted by an External reviewer not affiliated with Samaritan Health Services. This Designee which has the necessary clinical competence shall be provided with appropriate resources and information regarding the benefits of this plan to make a final decision. After completion of the review, you will receive a written notice, which will include:

1. the decision
2. the specific reasons for the denial if upheld, and
3. the specific reference to pertinent Plan provisions.

## Appeal timelines

Samaritan Choice Plans follows the following timeframes for making decisions on appeals:

- 72 hours for appeals of denied urgent care claims
- 30 days for appeals of pre-service claims
- 60 days for appeals of post-service claims

# Your member rights and responsibilities

## Your RIGHTS as a member:

- You have a right to receive information about Samaritan Choice Plans, our services, our providers, and your rights and responsibilities.
- You have a right to be treated with respect and recognition of your diversity and right to privacy.
- You have a right to participate with your healthcare provider in decision-making regarding your care.
- You have a right to honest discussion of appropriate or medically necessary treatment options.
- You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your medical information and records.
- You have a right to voice complaints about Samaritan Choice Plans or the care you receive, and to appeal decisions you believe are wrong.

## Your RESPONSIBILITIES as a member:

- You are responsible for providing Samaritan Choice Plans and our providers with the information we need to care for you.
- You are responsible for following treatment plans or instructions agreed on by you and your healthcare providers.
- You are responsible for payment of co-pays at the time of service.
- You are responsible for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this plan also understand them.
- You are responsible for making sure services are prior authorized when required by this plan before receiving medical care.

# 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.

## Rights to receive certificates

A certificate of creditable coverage will automatically be provided to a Covered Person upon the occurrence of certain events. In certain cases, a Covered Person, or someone on behalf of the Covered Person, may also request a certificate.

## Automatic provision of certificate

A Covered Person whose coverage under the Plan is to end (or which would end but for the right to elect COBRA continuation coverage) will automatically be provided a creditable coverage certificate. In that event, the certificate will be provided at the time the Covered Person will lose coverage under the Plan or within a reasonable time after such date.

In the case of a Covered Person who has elected COBRA continuation coverage, a certificate of creditable coverage will automatically be provided to the Covered Person within a reasonable time after the date such continuation coverage ends. In the event that such continuation coverage ends because of the non-payment of the required continuation coverage premium payments, then the certificate will be provided within a reasonable time after the end of any applicable payment grace period.

A certificate automatically provided to a Covered Person will disclose the last period of the Covered Person's continuous coverage under the Plan.

## Provision of certificate upon request

A Covered Person, or someone on behalf of a Covered Person, may 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 may be provided for each period of continuous coverage.

## Specification of benefits

A group health plan or issuer may 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 Claims Administrator may charge the requesting plan or issuer for the reasonable cost of providing such benefit information. Subject to the payment of such costs, the Claims Administrator will promptly provide to the requesting entity all of the requested information that is reasonably available to the Claims Administrator.

# Claims information

When a claim is submitted for payment every attempt will be made to process it promptly and accurately. Claims must be submitted within one year of the time the Covered Person receives the service or supply to be eligible for payment.

Within 30 days of receipt of a clean claim, the Claims Administrator will report to you on the action it has taken. This will be done on a form called an Explanation of Benefits. The Plan may pay claims, deny them, or accumulate them toward satisfying the Deductible. If the Claims Administrator denies all or part of a claim, the reason or reasons for the action will be stated in the Explanation of Benefits. The explanation will also contain the following items:

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

If the Covered Person receives payment for a benefit that he or she is not eligible to receive, the Plan has the right to recover the payment from the Covered Person (including by reducing future claim payments) or anyone else who benefits from it.

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

**Samaritan Choice Plans**

**PO Box 336**

**Corvallis, OR 97339-0336**

## HIPAA privacy notice

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

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

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact Samaritan Choice Plans at (541) 768-4550 or 1-800-832-4580.

# 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**

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.

# Plan administration

## **Other authorities and responsibilities**

Samaritan Health Services has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. Samaritan Health Services also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Samaritan Health Services, as the plan administrator, may give other decision-makers the authority to interpret the plan, to resolve and interpret any ambiguities that exist, and to make factual determinations on behalf of Samaritan Choice Plans.

The Plan is administered by Samaritan Health Plan Operations a division of Samaritan Health Services, the Plan Administrator, and the Named Fiduciary for all purposes except deciding benefit claims. The Human Resources Vice President of Samaritan Health Services is the person who acts on behalf of the Plan Administrator. Samaritan Health Services has agreed to indemnify the Human Resources Vice President for any liability that he or she incurs as a

result of acting on behalf of the Plan Administrator, unless such liability is due to his or her gross negligence or misconduct. Samaritan Health Services and Samaritan Health Plan Operations share a responsibility for administering the plan as discussed in this Plan Document.

## **Compliance with State and Federal mandates**

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the Plan Document, including the Employee Retirement Income Security Act of 1974 (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 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.

# Summary Plan Description

## General information

<b>Name of Plan</b>	Samaritan Health Services Benefit Plan Plan No. 505
<b>Name and Address of Plan Sponsor/Employer</b>	Samaritan Health Services 3600 NW Samaritan Drive Corvallis, OR 97330 You may obtain a current list of employers that have adopted the Plan by writing to the Administrator.
<b>Employer Tax ID Number</b>	93-0951989
<b>Type of Plans</b>	Group Medical Plan/Preferred Provider Organization
<b>Type of Administration</b>	Self-funded plan administered according to the Plan Document and agreement with the Claims Administrator, Samaritan Health Services.
<b>Name of Plan Administrator</b>	Samaritan Health Plan Operations, a division of Samaritan Health Services PO Box 336 Corvallis, OR 97339-0336 Telephone: (541) 768-4550 or 1-800-832-4580

<b>Agent for Service of Legal Process</b>	Doug Boysen, Vice President & General Counsel 3600 NW Samaritan Drive Corvallis, Oregon 97330 Telephone: (541) 768-4550 Legal process may also be served on the Administrator.
<b>Contributions</b>	Employer and employee contributions. Contribution rates are reviewed and determined by the Plan Sponsor in its sole discretion.
<b>Plan Year</b>	January 1 through December 31
<b>Plan Continuation</b>	The Employer intends to continue the Plan indefinitely, but it reserves the right to discontinue or change the Plan at any time, without the consent of any participant or beneficiary.  If the Plan ends, claims for Eligible Expenses Incurred before the Plan termination date will still be paid.

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**Modifications or Termination of the Plan**

The Plan may be amended from time to time by Samaritan Health Services to make any changes that it believes are appropriate, including, but not limited to, changes in benefits or eligibility requirements. The Plan may also be suspended or terminated at any time by Samaritan Health Services.

All modifications to the Plan Document must be in writing in order to be valid. No agent or employee other than a duly authorized corporate officer has the authority to modify the Plan or to waive any of its provisions.

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**No Guarantee of Employment**

Your participation in this Plan does not guarantee your continued employment with SHS. If you quit, are discharged or laid off, this Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan Document.

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## Customer service

The Samaritan Choice Plans office in Corvallis, Oregon is maintained to meet your servicing needs. Come see us at 815 NW Ninth Street, Avery Square Suite 101, or contact us at (541) 768-4550 or 1-800-832-4580. We look forward to serving you.

**Samaritan Choice Plans**

**PO Box 336**

**Corvallis, OR 97339**

**[www.samhealth.org/healthplans](http://www.samhealth.org/healthplans)**



*By Samaritan Health Services*

Samaritan Choice Plans  
Samaritan Health Plan Operations  
815 NW Ninth Street, Suite 101  
Corvallis, Oregon 97330  
(541) 768-4550  
1-800-832-4580  
TTY 1-800-735-2900  
[www.samhealth.org/healthplans](http://www.samhealth.org/healthplans)