Letter from PEBB

THE PUBLIC EMPLOYEES' BENEFIT BOARD

TO: State Employees and Non-Medicare Eligible Retirees

FROM: Public Employees' Benefit Board (PEBB)

The benefits described on the following pages were designed to provide you and your dependents with the best possible medical care at competitive rates. PEBB has designed this Plan in cooperation with Samaritan Health Plans. The benefits under the Plan are provided by PEBB on a self-insured basis. Because this Plan is self-insured, it is subject to PEBB's funding limitations, including but not limited to legislative appropriations, PEBB fund balances, and the limits imposed by laws that apply to PEBB. PEBB has contracted with Samaritan Health Plans to process claims and provide customer service to Participants. However, Samaritan Health Plans does not insure or otherwise guarantee any benefits under the Plan.

Should you require additional information concerning this medical plan or any other topic related to your medical coverage, please contact Samaritan Select at 541-768-6900, or 1-800-569-4616, or PEBB at 503-373-1102, 1-800-788-0520 (outside Salem), or via e-mail at inquiries.pebb@state.or.us.

If more than one year has lapsed since the effective date of your member handbook, benefits may have changed. In all cases, benefits will be administered in accordance with the governing plan documents, insurance contracts or applicable Federal and State regulations.

Introduction

The following pages are the booklet, a written description of the terms of the group medical care benefit plan that this booklet describes.

Please read this booklet as soon as you get it. It will tell you how the plans work. You'll then be able to obtain all the benefits you're entitled to and avoid delays in processing your claims.

This booklet is designed to explain the benefits and other provisions of the plan clearly and completely. This booklet is part of the group plan between Samaritan Select and the Public Employees' Benefit Board. The Public Employees' Benefit Board has a copy of this document.

Throughout this booklet, we use the term "covered employee" to refer to the employee or retiree. The term "covered dependents" and "family members" are used interchangeably to refer to your spouse, domestic partner, and eligible children. The term "you" applies to the covered employee or retiree and covered family members unless we indicate otherwise.

A special feature of your coverage is its "hold harmless" clause. Basically, this clause guarantees you that participating providers will not charge you beyond the fee upon which we base our payment. Of course, any applicable coinsurance or co-pay will continue to apply. Physicians who are not participating, however, may bill you for any balances over the maximum allowable charge.

Because this Plan is self-insured, it is subject to PEBB's funding limitations, including but not limited to legislative appropriations, PEBB fund balances, and the limits imposed by laws that apply to PEBB.

This booklet describes benefits effective January 1, 2008, or the date after that when your coverage became effective.

Table of contents

INTRODUCTION 3

DEFINITIONS... 9

ELIGIBLE CHARGES 11

Medically necessary 13
Participating facilities and providers 13
Preauthorization 13
What needs to be preauthorized................................. 13
2008 Medical Preauthorization List............................. 14
Preauthorization process... 15
Comprehensive Care Management.............................. 15
Medical bill audit... 16
Coverage outside the United States 16
Out-of-area network services—
National Access Program and MD Abroad.................... 16
Emergency care 17

SUMMARY OF BENEFITS 19

PPO Plan 19
PPO Part-Time and Retiree Plan 19
Eligible charges 19
Co-payment/coinsurance... 19
Maximum lifetime benefit.. 19
How long coverage lasts.. 19
Restoration of benefits... 19
Out-of-pocket maximum renewal................................ 19

2008 SUMMARY OF BENEFITS FOR PPO PLAN 21

2008 SUMMARY OF BENEFITS FOR PART-TIME AND RETIREE PLAN......... 23

WHAT KINDS OF SERVICES AND SUPPLIES ARE COVERED...............25

Care when you are admitted to a hospital
or skilled nursing facility.. 26
Rehabilitative hospital care 26
Newborn nursery care 26
Care in a special facility 26
Your benefits won't change while
you are hospitalized 26
Hospital outpatient care
(other than emergency room) 26
Outpatient rehabilitation 27
Physician bills for surgery.. 27
Assistant surgeon 27
Anesthesiologist 27
Surgical supplies 27
Physician visits in the hospital.. 27
Physicians' home and office visits..................................... 27
Therapeutic injections.. 27
Acupuncture, chiropractic and naturopathic care 28
Preventive care benefits 28
Women's health and cancer rights 29
Diagnostic X-rays and laboratory tests 30
Radium and radioisotope therapy 30
Ambulance benefits 30
Infertility services 30
Outpatient diabetic instruction 30
Maternity benefits 30
Contraceptive services 31
Home health care 31
Special dental care 31
Medications 31
Durable medical equipment and supplies 32
Palliative hospice care. 32
Home infusion therapy 33

LIMITATIONS APPLICABLE TO YOUR PLAN 35

Treatment for chemical dependency and/or mental illness 35

Biofeedback therapy 37

Bariatric surgery 37

Transplants 37

GENERAL EXCLUSIONS 41

BENEFITS TO BE PAID BY OTHER SOURCES 45

Motor vehicle coverage 45

Third-party liability 46

Workers' compensation 47

Medicare 47

Coordination of benefits 47

Other claims recoveries 50

HOW TO FILE A CLAIM 51

Hospital charges 51

When the hospital bills you 51

Physicians' charges 51

Filing a lawsuit 52

Other health care charges 52

Prescription medication rebates 52

Appliances 52

Ambulance service 52

Claim determinations 52

Explanation of benefits 53

When benefits are available 53

Out-of-area network services—National Access Program and MD Abroad 53

PRESCRIPTION MEDICATION PROGRAM 55

Prescription medication benefits replace plan benefits 55

Definitions 55

How to use the prescription medication benefit 56

Maximum out-of-pocket expense—PPO Part-Time and Retiree Plan only 57

Mail order benefit 57

How to obtain mail order medications 58

Exceptions process for non-preferred brand-name medications 56

Prescription medication plan limitations 56

Prescription medication plan exclusions 59

Preauthorization 60

General medication plan provisions 60

MEMBER APPEALS AND GRIEVANCE PROCESS 63

DISCLOSURE STATEMENT—PATIENT PROTECTION ACT 65

What are my rights and responsibilities as a member of Samaritan Select? 65

How do I access care in the event of an emergency? 66

How will I know if my benefits change or are terminated? 66

What happens if I am receiving care and my doctor is no longer a contracting provider? 66

When continuity of care applies 66

How long continuity of care lasts 66

Complaint and Appeals: If I am not satisfied with my health plan or provider, what can I do to file a complaint or get outside assistance? 67

What are your preauthorization and utilization review criteria? 67

How are important documents (such as my medical records) kept confidential? 67

My neighbor has a question about the plan that he has with you and doesn't speak English very well. Can you help? 68

What additional information can I get from you upon request? 68

What other source can I turn to for more information about your company? 68

RESCINDING COVERAGE 69

ELIGIBILITY 71

NOTICE OF TERMINATION 72

CONTINUATION COVERAGE RIGHTS UNDER COBRA 75

COBRA notice 75

Continuation coverage 75

Qualifying event for covered employee 75

Qualifying events for covered spouse or domestic partner 75

Qualifying events for covered dependent children 75

Important employee, spouse or domestic partner, and dependent notification requirements 76

Employer notification requirements. 76

Election period 76

Length of continuation coverage. 76

Eligibility and premiums 77

Address changes 77

Questions 77

GENERAL PROVISIONS 79

Group is the agent. 79

Relationship to Samaritan Health Services 79

MEMBER SERVICES. 81

Definitions

The following are definitions of some important terms used in the Member Handbook. Other terms are defined where they are first used in the text.

Illness means a physical illness or mental illness. Physical illness is a disease or bodily disorder. Mental illness is an Axis 1 diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those specially excluded in the GENERAL EXCLUSIONS Section.

Injury means a personal bodily injury to you or your covered dependent caused directly and independently of all other causes by external, violent, and accidental means.

A **preexisting condition** is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the enrollment date. Your coverage has no waiting period or exclusions for preexisting conditions.

An **emergency medical condition** means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency medical screening exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency services means those services and supplies furnished by a facility to the extent they are required for the stabilization of a patient who is experiencing an emergency medical condition.

A **covered dependent or family member** is an eligible dependent or domestic partner of a covered employee or retiree whose application is accepted by PEBB and who is covered by this plan.

A **covered employee** or retiree is an employee or retiree of the group whose application is accepted by PEBB and who is covered by this plan.

A **covered member** is a covered dependent or a covered employee or retiree.

A **preferred facility** is a hospital, skilled nursing facility, or special facility that has an effective Preferred Provider Plan contract with Samaritan Select to provide services and supplies to the covered individuals under this plan.

Preferred professional provider means a professional provider who has an effective Preferred Provider Plan contract with Samaritan Select to provide services and supplies to the covered individuals under this plan.

Contracting agency means any of the following with whom Samaritan Select has contracted to provide services and supplies to the covered individuals under this plan:

- Home health care agency;
- Home infusion therapy agency; and
- Hospice care program.

Contracting Durable Medical Equipment (DME) supplier means a supplier of durable medical equipment with whom we have contracted to provide services and supplies to covered individuals.

Maximum allowable charge means the contracted amount for listed services and supplies provided by a participating facility, participating professional provider, preferred facility, preferred professional provider, a contracting agency, or a contracting durable medical equipment supplier, or the billed amount, whichever is less.

Annual out-of-pocket maximum means the maximum dollar amount of coinsurance or co-payments you could pay for eligible charges in a calendar year. The amount of the annual out-of-pocket is shown in the SUMMARY OF BENEFITS.

Usual and customary or reasonable charge means:

- Usual—Not more than the provider's, dispenser's or vendor's usual charge for a given service or supply; and
- Customary—An amount which falls within the range of usual charges for the service or supply billed by most professional providers, dispensers or vendors of the same or similar service or supply in our service area; or
- Reasonable—An amount which is usual and customary or which because of unusual circumstances, inadequacy of data or other reasons is established by Samaritan Select on an individual basis.

We determine usual and customary or reasonable charges in accordance with a proprietary database on medical billing information.

Health benefit plan means any hospital-medical-surgical expense policy or certificate issue by insurers including health care service contractors and health maintenance organizations, and includes any benefit plan provided by a multiple employer welfare arrangement, as defined in the federal Employee Retirement Income Security Act of 1974 as amended (ERISA).

You or **your** means the covered employee, retiree, or dependent.

A special feature of your coverage is its "**hold harmless**" clause. Basically, this clause guarantees you that participating providers will not charge you beyond the fee upon which we base our payment. Of course, any applicable co-payment or coinsurance will continue to apply. Physicians who are not participating, however, may bill you for any balance over the maximum allowable charge.

Eligible charges

Subject to the terms of this policy, eligible charges means the following when incurred for the services and supplies (including medications) listed in the following sections and when medically necessary for diagnosis and/or treatment of an illness or injury:

- The contracted amount for listed services and supplies provided by a participating facility, participating professional provider, preferred facility, preferred professional provider, a contracting agency, or a contracting durable medical equipment supplier;
- The reasonable charge for listed services and supplies provided by a participating facility;
- The billed amount for listed services received from a non-participating professional provider, or the contracted amount for a participating professional provider for the same service, whichever is less;
- The billed amount for listed services and supplies provided by an agency other than a contracting agency for home health care, home infusion therapy, or palliative hospice care or the contracted amount for a contracting agency for the same service or supply, whichever is less;
- The billed amount for listed services and supplies provided by a durable medical equipment supplier that is not a contracting durable medical equipment supplier or the contracted amount for a contracting durable medical equipment supplier for the same service or supply, whichever is less;
- The usual and customary or reasonable charge for all other listed services and supplies.

For emergency services only (excluding ambulance transportation), we pay a non-preferred professional provider the same percentage of benefits as we would have paid a preferred professional provider for a similar service.

In addition, if your or your covered dependent's medical condition necessitated emergency services at a non-preferred facility, we pay the same percentage of benefits we would have paid for a similar service or supply at a preferred facility. However, after receiving covered emergency services at a non-preferred facility, we can require you to transfer to a preferred facility as soon as your medical condition safely permits. Payment for eligible charges for a non-preferred facility for care beyond the date we reasonably determine you can be safely transferred will revert back to the percentage payable for a non-preferred facility.

Preferred and participating providers will not charge you or your covered dependents for any balance beyond any coinsurance amount for eligible charges. Facilities and professional providers that do not have a preferred or participating contract with us, however, may bill you for any balance over the maximum allowable charge in addition to any coinsurance amount.

Example of how benefits are paid

Non-participating Professional Provider

Non-participating professional provider charge for a service:	$100.00
Amount allowed to a participating professional provider for the same service (the contracted amount):	$85.00
Amount considered an eligible charge for the non-participating professional provider's charge would be: *(non-participating professional provider's charge, not to exceed a participating professional provider's contracted amount for the same service)*	$85.00

How that eligible charge would be paid

Plan coinsurance for non-preferred providers: (Plan responsibility is 70 percent, your responsibility is 30 percent)	70%
Amount Plan would pay to the non-participating professional provider:	$59.50
Amount you would pay to the non-participating professional provider:	$40.50
Total:	$100.00

Difference between participating and non-participating professional provider payment

If the $100 charge had been for a visit to a participating professional provider, our payment to that provider would have been:	$75.00
Your responsibility would have been:	$10.00

The above is only an example. It assumes that you or your covered dependent has not met the annual out-of-pocket maximum amount. Not all eligible charges are subject to the annual out-of-pocket maximum. The actual benefits of the plan may vary. Read the SUMMARY OF BENEFITS thoroughly to determine how your benefits under the plan are paid.

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.

Participating facilities and providers

The important difference between the benefits for participating and preferred professional providers and facilities and non-participating and non-preferred professional providers and facilities is the balance you may be required to pay. Participating and preferred professional providers and facilities will not charge you or your dependents any balance for eligible charges over any applicable coinsurance or co-pay amount required under your plan. Non-participating and non-preferred providers and facilities, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance or co-pay.

Ask your professional provider or facility if they are a participating or preferred provider with Samaritan Select. You can also get a list of participating and preferred professional providers from our Samaritan Select office, or access on-line via our web site, www.samaritanselect.com.

IMPORTANT NOTE: It is extremely important to use participating and preferred facilities and participating and preferred professional providers in order to maximize your benefits available under this plan.

Preauthorization

Preauthorization is a tool we use to find the most appropriate and cost effective level of medical care for our member. Many types of treatment may be available for certain conditions; the preauthorization process helps your physician work together with you or your covered dependent, other providers, and Samaritan Select to determine the treatment that best meets your or your covered dependent's medical needs. This teamwork helps save thousands of dollars in premiums each year, which translates into savings for you.

Preauthorization refers to the process by which we determine that a proposed service or supply (including medications) is medically necessary and provide approval for it before it is rendered.

What needs to be preauthorized

Some services and supplies (as may be described in this benefits booklet) must be preauthorized before the Plan will consider paying the claim. These services and supplies are listed on the Plan's Preauthorization List below. Note that we do not preauthorize services or supplies, which are not included on the Plan's Preauthorization List.

Preauthorization by contracting providers—Providers that have contracted with Samaritan Select know how the preauthorization process works and will normally request preauthorization, if necessary, for your or your covered dependent's proposed service or supply.

Preauthorization by non-contracting providers—Your or your covered dependent's provider knows how this process works and will normally request preauthorization, if necessary, for you or your covered dependent's proposed service or supply. However, if you or your covered dependent receives care from a provider with whom Samaritan Select has not contracted, you or your covered dependent may be liable for charges the Plan denies because the service or supply is not medically necessary. Avoid that risk by asking your or your covered dependent's provider to contact the Samaritan Select Preauthorization Department.

2008 Medical Preauthorization List

Coverage of certain medical equipment, services and surgical procedures requires Samaritan Select written authorization before the services are performed. Your provider may request preauthorization from our office by phone, fax or mail. You must contact Samaritan Select yourself if for any reason your provider will not or does not request preauthorization for you. In some cases, additional information or a second opinion may be required before authorizing the service or procedure. More information on preauthorization requirements may be obtained by contacting our Customer Service Department at 541-768-6900 or 1-800-589-4616.

Samaritan Select Preauthorization Department
Phone: 541-768-6900 or 1-800-589-4616
Fax: 541-768-4211

Durable medical equipment (DME)

- Equipment purchase or repair with billed charges over $1,500 for any single line item or component.
- Equipment rental with billed charges over $500/month for any single line item or component.
- Extremity prosthetics with billed charges over $5,000 for any single line item or component

Inpatient services

- All out-of-area admissions from first day of stay
- Length of stay greater than 10 days
- Rehabilitation
- Skilled nursing facility (SNF)
- Transplants, ventricular assist devices (preauthorization not required for members requesting corneal transplants)

Home services

- Home health services including initial evaluations
- Home infusion therapy by providers without specific home infusion contracts
- Hospice

Other services and procedures

- Cosmetic or potentially cosmetic procedures
- Investigational or potentially investigational services
- Non-participating providers
- Obesity services including but not limited to work-up, treatment and surgery
- Orthognathic surgery
- Spinal surgery
- Hysterectomy

Notifications required

- All inpatient admissions
- Pregnancy: Providers are required to notify us of pregnancies within two weeks of the member's first prenatal visit.

Pharmaceuticals and injectibles

See the PRESCRIPTION MEDICATION PROGRAM Section of the Member Handbook or call us for information.

Chemical dependency and mental health

Reliant Behavioral Health
Phone: (866) 724-9847
Fax: (877) 730-5113

- All Inpatient/residential
- Outpatient at 9th visit

If you receive services or procedures listed above without obtaining the required prior authorization, you will be held responsible for the expense. All preauthorizations are valid as noted or for 90 days, unless your coverage under the plan terminates before the services is performed.

If at any time you are unsure if an expense will be covered, contact Samaritan Select's Customer Service Department at 541-768-6900 or 1-800-589-4616. Preauthorization is not a guarantee of payment. Benefits are always subject to patient eligibility, contract limitations, benefits used and benefit maximums effective at the time services are rendered.

Preauthorization process

When we receive a preauthorization request from you or your covered dependent, or your or your covered dependent's provider, we will notify you or the provider of our decision within 15 days of our receipt of the preauthorization request. However, this 15-day period may be extended an additional 15 days in the following situations:

- When we cannot reach a decision due to circumstances beyond our control, we will notify you or the provider within the initial 15-day period that the extension is necessary and when we expect to reach a decision.
- When we cannot reach a decision due to lack of information, we will notify you or the provider within the initial 15-day period that the extension is necessary, including a specific description of the additional information needed. You or your provider must provide us with the requested information within 45 days of receiving the request for additional information. Once we receive the needed information,
  we will notify you of our decision within 48 hours after you supplied it to us or at the end of the period we allowed you to supply the needed information to us.

Our Preauthorization Department may be reached by phone or mail at:

- Mail:
  Samaritan Select Health Plans
  PO Box 1310
  Corvallis, OR 97339-1310
- Telephone:
  541-768-6900
  Toll-free: 1-800-569-4616
- Fax:
  541-768-4211

If we approve a preauthorization request from a provider, we are bound to cover the authorized service or supply as follows:

- If your or your covered dependent's coverage terminates within five business days of the preauthorization date, we will cover the preauthorized service or supply if the service or supply is actually incurred within those five business days regardless of the termination date unless we are aware the coverage is about to terminate and we disclose this information in our written preauthorization. In that case, we will only cover the preauthorized service or supply if incurred prior to termination
- If your or your covered dependent's coverage terminates later than five business days after the preauthorization date, but before the end of 30 calendar days, no service incurred after termination will be covered even if preauthorized.
- If coverage remains in effect for at least 30 calendar days after the preauthorization, we will cover the preauthorized service or supply if incurred within the 30 calendar days.
- When counting the days described above, day one will begin on the calendar or business day after we preauthorized the service or supply.

Comprehensive Care Management

Comprehensive Care Management is a program we administer that is designed to assist covered persons in getting the care they need while making the best use of their plan benefits by providing early detection and intervention in cases of serious illness or injury with the potential for major continuing claims expense.

We will, on a continuing basis, monitor claims activity of the group and identify potential cases for individual care management. Once identified, we will evaluate the individual case and may:

- Provide health care options;
- Recommend educational programs;

- Provide liaison between providers of medical care;
- Provide liaison between the attending physician and the hospital discharge planner; or
- Design a plan of benefits for alternative benefits to meet the individual needs of the patient.

Alternative benefits means payment for services or supplies which are not otherwise benefits of the policy, but which we believe to be medically necessary and cost effective. We will not cover alternative benefits until we have determined, at our sole discretion, to do so, and have received agreement in writing on the specific terms and conditions for payment signed by the covered person or the covered person's legal representative. The fact that we pay alternative benefits for a covered person shall not obligate us to pay such benefits for other covered persons, nor shall it obligate us to pay continued or additional alternative benefits for the same covered person. Benefits for alternative benefits are covered expenses for all purposes under this policy.

Medical bill audit

Enrollment in the Samaritan Select makes you eligible for a medical bill audit incentive. If you find an overcharge on your medical bill and convince the hospital or medical provider to correct it, you will be rewarded with up to 50 percent of the amount of the error. There is a minimum reward of $25 (error of $50) and a maximum reward of $100 (error of $200 or greater). To collect your reward, you must submit copies of the following: 1) original bill showing error, 2) Samaritan Select Explanation of Benefits, and 3) a complete PEBB Medical Bill Audit Claim Form (including the hospital or medical provider's acknowledgment of the error). Submit your claim(s) to the Public Employees' Benefit Board, 775 Court Street NE, Salem, OR 97301. Claims forms may be obtained by calling PEBB at 503-373-1102 or 1-800-788-0520 (outside Salem). This program may be changed or discontinued without notice.

Coverage outside the United States

Samaritan Select provides coverage for medically necessary health care services received outside the United States. Please see the section below for more information on our how you can maximize your benefits when traveling or living abroad.

Outside the United States, you may be required to pay for services when they are preformed. It is important that you obtain the most itemized billing possible, and ask to have bills written in foreign language translated into English. If this is not possible, Samaritan Select will translate the bills. Reimbursement for services received in a foreign country is based on the rate of exchange in effect on the date the service was provided.

Once you have returned to the United States forward these bills to our office and include your group and identification numbers. Claims for all types of health care services must be submitted within one year of the date of service.

Out-of-area network services—National Access Program and MD Abroad

Samaritan Select participates in two participating provider networks, the National Access Program and MD Abroad. These networks benefit covered individuals who incur eligible charges outside our service area.

Under Samaritan Select, when you or a covered dependent receives covered health care services outside our service area from a provider who has a participating contract with National Access Program or MD Abroad the amount you pay for eligible charges is usually calculated on the lower of:

- The actual billed charges; or
- The negotiated price that National Access Program or MD Abroad passes on to us.

Often, this "negotiated price" will consist of a simple discount. But, sometimes it is an estimated price that factors into the actual price, expected settlements, withhold, or other non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average excepted savings with your provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) in the price and may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

National Access Program

This Network is to be used when you do not have access to any type of medical professional that is within your Samaritan Preferred Provider Network within the USA. They will be sending you an ID card for their network soon after you become eligible with Samaritan Select. This card can be used in situations such as, but not limited to: when you are away on vacation, a child is away for school, or other reasons, or you or your covered spouse is away on business. Please contact Samaritan Select Customer Service at 541-768-6900 or 1-800-589-4616 for information about obtaining a Medical Home Provider for members living out of our service area.

To locate providers who participate within the National Access Program, please see the link on our web site, www.samaritanselect.com or call us for assistance at 541-768-6900 or 1-800-589-4616.

MD Abroad

Your participating provider network outside the USA is MD Abroad. Their logo is on the back of your Samaritan Select ID card for easy reference. To find a participating provider please call us for assistance at 541-768-6900 or 1-800-589-4616.

Samaritan Select Customer Service agents can also help you access these programs. Please see the participating provider information under the Eligible Charges section of this document for further information.

Emergency care

You and your covered dependents are covered for emergency medical screening exam expenses (see DEFINITIONS section) under the various sections of this policy without preauthorization.

Should you or your covered dependent experience an emergency medical condition, you or your covered dependent should seek medical attention from the nearest appropriate facility (physician's office, clinic setting, urgent care center, or hospital emergency room), or call 911.

Summary of benefits

This section is a summary of the benefits of the plan. It states the co-pays and coinsurance amounts for eligible charges and describes any annual out-of-pocket maximum amounts. It also states benefit maximums applicable to the coverage. You may also be responsible for payment of part of the premium for coverage under the plan. Check with your plan administrator for information on any required premium contribution. The sections following this SUMMARY OF BENEFITS spell out the benefits and the conditions, limitations, and exclusions of the plan in detail.

We have contracted with professional providers and facilities to provide services and supplies to covered employees and their covered family members under this plan. Our web site provider directory lists the Samaritan Select panel of providers that applies
to your benefits under the plan.

PPO Plan

This plan includes a co-pay or coinsurance percentage amount each time you receive a covered service. Active full- and part-time employees, retirees, covered family members, COBRA participants and self-pay individuals may be enrolled in this plan.

PPO Part-Time and Retiree Plan

This plan includes a percentage coinsurance amount each time you receive a covered service. Part-time employees receiving less than a full-time state contribution, retirees and their covered family members retirees may be enrolled in this plan.

Eligible charges

All services must be medically necessary and all payments are based on eligible charges for such services and supplies (see DEFINITIONS Section.)

Co-payment/coinsurance

This is the amount you must pay for services received as described in the SUMMARY OF BENEFITS. Co-payment is a flat dollar amount. Coinsurance is a percentage of eligible charges.

Maximum lifetime benefit

The maximum lifetime benefit is $2,000,000 per covered member.

How long coverage lasts

Each person's coverage lasts until your group's agreement with Samaritan Select ends, or until the $2,000,000 lifetime maximum of benefits is used up, whichever comes first.

Restoration of benefits

If you or one of your covered dependents receives medical benefits under this plan, the amount of those benefits up to $25,000 will be restored each January 1 to your or your covered dependent's maximum lifetime benefit.

Out-of-pocket maximum renewal

Out-of-pocket maximum provisions are calculated on a calendar year basis (January 1 to December 31). This plan also renews each calendar year, therefore out-of-pocket maximums renew each January 1.

2008 Summary of benefits for PPO Plan

Medical services

	Preferred Providers	Non-Preferred Provider
Annual out-of-pocket maximum	$1,000/person; $3,000/family	$2,000/person; $6,000/family
Individual lifetime maximum	$2 million	
Service	**You Pay Preferred**	**You Pay Non-Preferred**
Office visit		
Primary care office visit	$10	30%
Specialist office visit	$10	30%
X-ray and lab	$0	30%
Preventive care		
Periodic health appraisals	$0 [1, 2]	30% [1, 2]
Well-child check ups (to age 19)	$0 [1]	30% [1]
Hearing screenings	$0	30%
Routine immunizations	$0	$0
Mammography screening	$0 [1]	30% [1]
Routine women's exam	$0 [1]	30% [1]
Bone density screening	$0 [3]	30% [3]
Colonoscopy screening	$0 [1]	30% [1]
Prostate screening	$0 [1]	30% [1]
Diabetes and asthma care	$0	30%
Hearing		
Hearing exam	$10 [4]	30% [4]
Hearing aids, up to $4000 (every 4 years)	10% [4]	10% [4]
Hospital		
Ambulance	$75 [3, 5]	$75 [3, 5]
Inpatient, unlimited days	$100/day, $500/year	30%
Outpatient	$10	30%
Emergency room	$75 [3, 5]	$75 [3, 5]
Maternity and gynecology		
Prenatal and postpartum office visits	$10	30%
Inpatient delivery	$100/day, $500/year	30%
Infertility treatment	50% [6]	50% [6]
Surgery		
Inpatient	$0 [7]	30% [7]
Outpatient	$10 [7]	30% [7]

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Medical services continued

Service	You Pay Preferred	You Pay Non-Preferred
Office-based	$10 [7]	30% [7]
Mental health and chemical dependency		
Inpatient and residential	$100/day, $500/year [6, 7]	30% [6, 7]
Outpatient	$10 [6, 7]	30% [6, 7]
Durable medical equipment	15%	30%
Insulin, diabetic supplies	$0	$0
Alternative care	$15 [8]	$15 [8]
Misc. services		
Outpatient rehab	15%	30%
Injectibles and therapeutic injectibles	15%	30%
Cardiac rehab	15%	30%
Home health	15%	30%
Skilled nursing facility	15%	30%

Pharmacy services

Service	
Prescription drugs	**Participating pharmacies only**
Retail	**34-day supply**
Therapeutic	$0
Generic	$5
Brand	$15
Non-preferred brand	>$50 or 50% plus [9]
Mail order	**90-day supply**
Therapeutic	$0
Generic	$12.50
Brand	$37.50
Non-preferred brand	>$125 or 50% plus [9]

[1] Based on plan's frequency schedule.
[2] Includes commercial driver's license medical exam for employee.
[3] When medically appropriate.
[4] Hearing aids covered at $4000 every 4 years.
[5] Based on criteria including prudent layperson law.
[6] Some diagnoses and treatments may not be covered benefits.
[7] Some services require prior authorization.
[8] Includes chiropractic, naturopathic and acupuncture services.
[9] Plus the difference between generic and brand for multisource brands. Multisource brand—a brand where there is an exact generic equivalent available.

Vision services

Routine vision care covered through VSP.

2008 Summary of benefits for Part-Time and Retiree Plan

Medical services—part-time and retiree

	Preferred Providers	Non-Preferred Provider
Deductible	50% of $1,000 then 20%	50% of $1,000 then 50%
Annual out-of-pocket maximum	$2,000/person; $6,000/family	$4,000/person; $12,000/family
Individual lifetime maximum	$2 million	
Service	**You Pay Preferred**	**You Pay Non-Preferred**
Office visit		
Primary care office visit	20%	50%
Specialist office visit	20%	50%
X-ray and lab	20%	50%
Preventive care		
Periodic health appraisals	$0 [1, 2]	50% [1, 2]
Well-child check ups (to age 19)	$0 [1]	50% [1]
Hearing screenings	$0	50%
Routine immunizations	$0	50%
Mammography screening	$0 [1]	50% [1]
Routine women's exam	$0 [1]	50% [1]
Bone density screening	$0 [3]	50% [3]
Colonoscopy	$0 [1]	50% [1]
Prostate screening	$0 [1]	50% [1]
Diabetes and asthma care	$0	50%
Hearing		
Hearing exam	20% [4]	50% [4]
Hearing aids, $4000 (every 4 years)	10% [4]	10% [4]
Hospital		
Ambulance	20% [3, 5]	50% [3, 5]
Inpatient, unlimited days	20%	50%
Outpatient	20%	50%
Emergency room	20%	50%
Surgery		
Inpatient	20%	50%
Outpatient	20%	50%
Office-based	20%	50%
Maternity and gynecology		
Prenatal and postpartum office visits	20%	50%
Inpatient delivery	20%	50%
Infertility treatment	50% [6]	50% [6]

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Medical services continued

Service	You Pay Preferred	You Pay Non-Preferred
Mental health and chemical dependency		
Inpatient and residential	20% [6, 7]	50% [6, 7]
Outpatient	20% [6, 7]	50% [6, 7]
Durable medical equipment	20%	50%
Insulin, diabetic supplies	0%	0%
Alternative care	50% [8]	50% [8]
Misc. services		
Outpatient rehab	20%	50%
Injectibles and therapeutic injectibles	20%	50%
Cardiac rehab	20%	50%
Home health	20%	50%
Skilled nursing facility	20%	50%

Pharmacy services—part-time and retiree

Service	
Prescription drugs	**Participating Pharmacies Only**
Retail	**34-day supply**
Therapeutic	$0
Generic	$10
Brand	20%
Non-preferred brand	>$50 or 50% plus [9]
Mail Order	**90-day supply**
Therapeutic	$0
Generic	$25.00
Brand	$62.50
Non-preferred brand	>$125 plus [9]

Vision services—part-time and retiree

Not covered.

[1] Based on plan's frequency schedule.
[2] Includes commercial driver's license medical exam for employee.
[3] When medically appropriate.
[4] Hearing aids covered at $4000 every 4 years.
[5] Based on criteria including prudent layperson law.
[6] Some diagnoses and treatments may not be covered benefits.
[7] Some services require prior authorization.
[8] Includes chiropractic, naturopathic and acupuncture services.
[9] Plus the difference between generic and brand for multisource brands. Multisource brand—a brand where there is an exact generic equivalent available.

What kinds of services and supplies are covered?

Note: Throughout this section, the term "physician" means:

- Doctor of medicine or osteopathy;
- Podiatrist;
- A dentist (doctor of medical dentistry or doctor of dental surgery, or a denturist), but only for treatment of accidental injuries as described under the Special Dental Care benefit;
- Psychologist;
- Nurse practitioner;
- Direct entry midwives;
- Christian Science practitioner;
- Licensed counselor;
- Acupuncturist*;
- Naturopath*;
- Chiropractor*;
- Registered physical, occupational, speech, or audiology therapist;
- Registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services which nurses customarily bill patients;
- Licensed professional counselor and licensed marriage and family therapist;
- Audiologists; and
- Licensed clinical social worker.

** Eligible charges for services of an acupuncturist, a naturopath, and/or a chiropractor will be paid as shown in the SUMMARY OF BENEFITS, subject to plan limits. Exclusions are listed in the GENERAL EXCLUSIONS Section.*

The patient must personally see the provider for the billed services in order for us to pay benefits. Each of these providers must act within the scope of a valid license.

The term "**professional provider**" does not include any other class of provider not named previously, and no benefit of the policy will be paid for their services.

Care when you are admitted to a hospital or skilled nursing facility

If a physician orders you admitted to a hospital or skilled nursing facility we will pay a percentage of the eligible charge based on the daily semi-private room charge.

The semi-private room charge normally includes the cost of meals and general nursing care. We'll also pay the percentage shown in the SUMMARY OF BENEFITS for most other hospital services and supplies that are necessary for treatment and ordinarily furnished by the hospital. If your physician orders you hospitalized in an isolation area or intensive care unit, we'll pay the percentage of the charge listed in the SUMMARY OF BENEFITS.

Please Note: Skilled nursing facility admissions are limited to a maximum of 180 days per admission.

Rehabilitative hospital care

Eligible charges are limited to 30 days of rehabilitative care each calendar year for an inpatient stay in a hospital that has a specialized department for providing such care. However, for treatment required following head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per calendar year. These benefits will continue only as you or your covered dependent requires the full rehabilitative team approach and services can only be provided on an inpatient basis. In order to be an eligible charge, rehabilitative services must be part of a physician's formal written program to improve and restore lost function following illness or injury. The services must be consistent with the condition that is being treated. We will cover neurodevelopment therapy for children age six years and under when such services are for maintenance of a child whose condition would otherwise deteriorate without the service.

Newborn nursery care

We cover routine nursery care of an eligible, well-newborn infant at the Hospital/Inpatient benefit. Covered expenses of an ill or injured newborn are also covered at the Hospital/Inpatient benefit. See "Care when you are admitted to a hospital or skilled nursing facility" above for further information.

Care in a special facility

Your inpatient hospital benefit can be used for services provided in an approved non-hospital facility that offers specialized care, such as a birthing center. We pay benefits for eligible charges in these facilities as an alternative to your inpatient hospital benefit.

Your benefits won't change while you are hospitalized

If your plan's benefits change while you are in the hospital, we'll cover your entire hospital stay at the level of benefit that was in effect when you were admitted. The same rule applies to stays in other kinds of medical facilities.

Hospital outpatient care (other than emergency room)

We will pay eligible charges as listed in the SUMMARY OF BENEFITS for eligible services and supplies you receive in the outpatient department.

Examples include:

- Outpatient Surgery; and
- X-ray, radium and radioisotope therapy.

Outpatient rehabilitation

We cover up to 60 sessions each calendar year for rehabilitative services provided by a professional provider to a patient who is not confined to a hospital. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Rehabilitative services also include therapy for children age seventeen and under with a pervasive developmental disorder (defined as Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation). In order for us to cover any therapy, it must be part of a written plan of treatment prescribed by a physician.

Eligible charges do not include more than one session of any one kind of rehabilitation on one day. Nor do they include rehabilitative care provided in the patient's home and covered under the Home Health Care benefit, recreational or educational therapy, self-help or training, or treatment of psychotic or psychoneurotic conditions.

Physician bills for surgery

The surgery benefit applies to the physician's fee for operations as well as for treatment of dislocations and fractures.

Eligible charges for surgery (operative and cutting procedures), including treatment of fractures, dislocations, and burns are covered as follows:

- The primary surgeon;
- The assistant surgeon;
- The anesthesiologist or certified anesthetist;
- Surgical supplies, such as sutures and sterile set-ups, when surgery is performed in the physician's office; and
- Colonoscopy, sigmoidoscopy, and barium enemas.

When more than one surgical procedure is performed through the same incision during a single operative session, benefits will be payable on only the major procedure.

For bilateral procedures or procedures performed through different incisions in a single operative session, we will pay the first procedure at normal policy benefits, the second procedure at a percentage no more than 50 percent of normal policy benefits and any subsequent procedures at a percentage no more than 25 percent of normal policy benefits.

Assistant surgeon

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for the services of an assistant surgeon.

Anesthesiologist

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for the services of a professional anesthesiologist.

Surgical supplies

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for surgical supplies, such as suture kits and sterile setups.

Physician visits in the hospital

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for visits by your physician during your hospital or skilled nursing facility stay unless you are recuperating from surgery. If that is the case, your physician's visits will probably be included in his or her surgical fee. Visits by a consulting specialist will be paid for eligible charges as shown in the SUMMARY OF BENEFITS.

Physicians' home and office visits

Your coverage provides benefits for physicians' home and office visits for eligible charges shown in the SUMMARY OF BENEFITS.

Therapeutic injections

We cover therapeutic injections, such as allergy shots, when given in a professional provider's office, except when comparable results can be obtained safely with home self-care or through oral use of a prescription medication.

Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

Covered expenses under this therapeutic injection benefit apply only to administrative charges. Medicine charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the other provisions of the policy, subject to any deductible and/or coinsurance.

Acupuncture, chiropractic and naturopathic care

Acupuncture therapy, care received from chiropractors, and/or naturopathic care may be approved for services within the scope of the provider's license. Eligible providers of acupuncture are doctors of medicine or osteopathy or registered acupuncturists.

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS.

Co-pay amounts you are responsible for do not apply toward the annual out-of-pocket maximum amount.

Exclusions
Nutritional supplements are not covered (see Vitamin And Fluoride exclusions in the GENERAL EXCLUSIONS Section). Procedures and tests that are not medically necessary and/or are investigational are not covered (see Experimental or Investigational Services provision of the GENERAL EXCLUSIONS Section). Please see the GENERAL EXCLUSIONS Section for additional excluded services.

Preventive care benefits

Preventive care benefits are provided under four categories: periodic screening, well-baby care, routine periodic health appraisals, and immunizations. The benefit we pay is based upon the diagnosis that the doctor puts on your bill. If the diagnosis shows that the purpose of your care was preventive, then this benefit will be applied instead of any other benefit. If the diagnosis shows that care was for treatment of an illness or injury, regular policy benefits will be applied instead of preventive care benefits. If a claim has two diagnoses, we will pay claim on the diagnosis that will give you the higher benefit. However, we will pay benefits based on one diagnosis only.

Well-baby care including periodic screening
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for routine periodic health appraisals and periodic screening of your covered dependent children under two years of age. For covered dependents two years of age and over, see Routine Periodic Health Appraisals information.

We will pay for standard hospital exams at birth plus eight well-baby visits the first two years of life. Examinations include related laboratory tests and x-ray examinations.

Routine periodic health appraisals
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for routine periodic health appraisals based on the schedule that follows or as required by your Medical Home provider:

Age 2– 6	one exam every year
Age 7 – 18	one exam every two years
Age 19 – 34	one exam every four years
Age 35 – 59	one exam every two years
Age 60 and over	one exam every year

Routine periodic health appraisals include routine physical examinations, physical examinations required for school and/or to participate in athletics according to the schedule noted above, physician charges, and related laboratory and x-ray tests (handling fees are not covered).

Included in the above examinations are prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test for men age 50 or older, or as determined by the treating physician for men of any age who are at high risk for prostate cancer.

Laboratory and X-ray tests associated with a routine exam
We will pay the charges associated with administration of diagnostic tests when ordered by a physician. Eligible charges for these services are paid at the percentage shown in the SUMMARY OF BENEFITS.

Commercial Driver's License examinations

Employment related Commercial Driver's License (CDL) examinations for the covered state employee only are covered under this routine periodic health appraisal provision. This benefit includes the urinalysis required with the initial examination, but does not include additional urinalysis testing that may be required by the employer.

Annual women's examinations

Annual women's breast, pelvic and Pap smear examinations are covered once every calendar year. However, more frequent examinations will be covered if medically necessary and recommended by your medical home or woman's health care provider. By breast examination, we mean a complete and thorough exam of the breast for women age 18 or older, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Any eligible charges for laboratory, x-ray procedures, or mammography that accompany the examination will be covered according to the Diagnostic X-rays and Laboratory Tests provision, however, routine mammographic breast screening will be covered according to the following schedule:

Age 35 – 40: one mammogram in that period

Age 40 and above: one mammogram per calendar year

More frequent mammograms will be covered if medically necessary and recommended by your medical home or woman's health care provider. Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS.

Immunizations

We will pay as listed in the SUMMARY OF BENEFITS for immunizations and inoculations regardless of your or your covered dependent's age. Immunizations for purposes of travel are eligible benefits.

Hearing examinations and hearing aids

We will pay eligible charges as listed in the SUMMARY OF BENEFITS for one hearing examination every 12 months. We will also allow for the purchase of hearing aids once every 4 years up to a maximum of $4,000 with a 10% member coinsurance. The hearing aid benefit is not subject to the out-of-pocket maximum.

Exams and screenings for colonoscopies

We will pay for services associated with the exam and screening of colonoscopies every 10 years for members age 50 and over, and every two years for designated high-risk patients. Eligible charges for these services are paid at the percentage shown in the SUMMARY OF BENEFITS.

Prostate exams and PSA testing

We will pay charges relating to the prostate examination and testing for men age 50 and over. Eligible charges for these services are paid at the percentage shown in the SUMMARY OF BENEFITS.

Bone density screenings

Bone density screenings are covered as medically necessary.

Diabetic and asthma care

Member cost shares, including co-pays and coinsurance, will be waived for specific services directly related to Diabetic and Asthma care. These services include office visits and certain laboratory testing. Eligible charges for these services are paid at the percentage shown in the SUMMARY OF BENEFITS. For Part-time/Retiree members, the charges will not be applied to your annual deductible

Exclusions

Routine examinations and immunizations for the purpose of employment, insurance, or licensing are not covered except in the case of CDL coverage as described above.

Women's health and cancer rights

If you or your covered dependent is receiving benefits in connection with a mastectomy and you or your covered dependent, in consultation with the attending physician, elects breast reconstruction, we will provide coverage for:

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

Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., coinsurance, and annual out-of-pocket maximums).

Diagnostic X-rays and laboratory tests

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for diagnostic radiology (including CT and MRI) or laboratory tests related to the treatment of an illness or injury. Preadmission testing preformed on an outpatient basis is covered as shown in the SUMMARY OF BENEFITS.

Radium and radioisotope therapy

Your coverage pays charges as shown in the SUMMARY OF BENEFITS for radium and radioisotope therapy. Eligible charges for these therapies other than for professional services are also covered under the hospital outpatient benefit of this plan.

Ambulance benefits

Your coverage pays eligible charges based on community standards as determined by Samaritan Select for local ground transportation by state certified ambulance up to 500 miles per calendar year. This is for transportation to the nearest hospital that has facilities to give the necessary treatment. Certified air ambulance transportation will be covered if it is medically necessary, based on usual and customary or reasonable charges. Emergency benefits, excluding ambulance transportation, will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition (see DEFINITIONS Section of this document).

We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will reimburse you directly.

Infertility services

Covered infertility services will be limited to artificial insemination, including services related to or supporting artificial insemination, when medically necessary, subject to a 50 percent coinsurance. Infertility medications, in vitro and in vivo fertilization, including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures we determine to be experimental or investigational in nature will not be covered.

Coinsurance amounts you are responsible for do not apply toward the annual out-of-pocket maximum amount.

Outpatient diabetic instruction

(This benefit is not subject to any co-payment or coinsurance provisions of the policy.)

Services and supplies used in outpatient diabetes self-management programs as described here are covered under this policy when they are provided by a health care professional or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes. For the purposes of this benefit, a health care professional means a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with demonstrated expertise in diabetes. We will waive any required co-payment and pay 100 percent of the billed charges for one outpatient diabetes self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medications, supplies, and equipment not included in the charge for the outpatient diabetes self-management program are covered elsewhere under the policy.

The benefits paid for diabetic instruction under this policy do not apply to the annual out-of-pocket maximum.

Maternity benefits

We will pay eligible charges shown in the SUMMARY OF BENEFITS for maternity care.

To the extent this policy provides coverage for maternity care, we will not limit benefits for the mother and her newborn's length of inpatient stay (beginning with the time of admission) to less than 48 hours for a normal delivery and 96 hours for a cesarean section. However, the attending physician in consultation with the mother may decide on an early discharge. Such hospitalization does not need to be preauthorized.

Contraceptive services

Eligible charges for certain professional provider contraceptive services are covered, including but not limited to vasectomy, tubal ligation, and insertion of IUD or Norplant (the actual prescription contraceptive may be covered elsewhere under the policy.)

Home health care

Home health care services and supplies as described in this section when provided by a home health care agency for a patient who is homebound. By "homebound" we mean that the condition of the patient is such that there exists a general inability to leave home. If the patient does leave home, the absences must be infrequent, of short duration and mainly for receiving medical treatment. A home health care agency is a licensed public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in the patient's home.

We will cover up to 180 intermittent medically necessary home health care visits per calendar year. A "visit" must be for intermittent care of not more than two hours in duration. Home health care services must be ordered by and require the training and skills of one of the following providers:

- A registered or licensed practical nurse;
- A physical, occupational, speech, or respiratory therapist; or
- A licensed social worker.

Please Note: This home health care benefit does not include home care services provided as part of a hospice treatment plan, nor do the charges for the services of a licensed social worker paid according to this Home Health Care benefit count against the benefit maximums for treatment of mental illness. See the "Palliative hospice care" benefit and "Treatment for chemical dependency and/or mental illness" limitation for a description of those benefits.

Maximum visits

There is a two-visit maximum allowed in any one day for the service of registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.

Preauthorization

If home health care is provided by an agency other than a contracting agency, we strongly urge you to contract our Preauthorization Department before receiving such care. See "Preauthorization" subsection for a description of the preauthorization process.

Special dental care

Your plan covers treatment of accidental injury to natural teeth or a fractured jaw, if the treatment is given by a physician or a dentist. Natural teeth are healthy teeth, teeth that have been restored to a sound condition, or teeth that have been replaced by a fixed or removable partial denture or bridge. Diagnosis must be within six months of the injury and benefits will be available for treatment provided within 12 months of the injury except when completion is delayed due to healing time following medically necessary surgery. The injury must be one that occurred while you or your covered dependent was enrolled under this policy. For purposes of this Special Dental Care benefit, injury does not include accidents that occur during eating, biting, or chewing.

Orthognathic surgery is not reimbursable as a benefit for temporomandibular joint (TMJ). Because TMJ is not directly related to the tooth or supporting services, we consider TMJ to be medical treatment. TMJ medical therapy services are limited to the examination, x-rays, physical therapy, TMJ splint, and surgical procedures appropriate for TMJ. Services directly related to the tooth or supporting structure are considered dental procedures even when provided to a patient diagnosed with TMJ. Examples of these services include occlusal equilibration, full mouth reconstruction, orthodontia services, and dentures.

Medications

Your coverage pays for the following medically necessary medications when required by standard treatment practices for the treatment of an illness or injury:

- **Non-prescription elemental enteral formula** for home use when ordered by the patient's physician as long as:
  - The formula is medically necessary for the treatment of severe intestinal malabsorption; and

- The formula comprises the sole or an essential source of the patient's nutrition;

- **Medical foods,** such as PKU formula, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which there exists medically standard methods of diagnosis, treatment, and monitoring. Medical foods means foods that are:
  - Formulated to be consumed or administered enterally under the supervision of a physician;
  - Specially processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts;
  - For the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients, or have other specific nutrient requirements as established by medical evaluation; and
  - Essential to optimize growth, health, and metabolic homeostasis.

Charges for diagnosis, treatment, and monitoring of the disorder requiring medical foods are covered elsewhere in the policy.

Durable medical equipment and supplies

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for medically necessary artificial eyes, limbs, and appliances when required by standard treatment practices for the treatment of an illness or injury.

The term durable medical equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the covered person's home. Examples include oxygen equipment and wheelchairs. Durable medical equipment may not serve solely as a comfort or convenience item.

Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts, usually serve as convenience items. They are generally not eligible for benefits unless medical necessity can be established from diagnosis and treatment. However, if medical necessity is established and preauthorization is granted, we will cover motor-driven wheelchairs and seat-lift mechanisms.

Environmental modifications such as wheelchair ramps or elevators for the home, and devices and equipment used for environmental setting such as air conditioners, humidifiers, air filters, and portable whirlpool pumps, are not considered durable medical equipment under this policy and are not covered.

We cover the following durable medical equipment and supplies:

- Casts, trusses, limb or back braces, crutches, and orthotics (must be custom made; casting charges included);
- Artificial limbs and eyes and maxillofacial prosthetic devices (maxillofacial prosthetic devices must be medically necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue,
  are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function);
- Rental (not to exceed the reasonable purchase price) of a wheelchair, hospital-type bed, or other durable medical equipment. If your physician thinks you will not need the equipment long enough for the rental costs to exceed the purchase price; and
- Other supplies including:
  - Contraceptive devices;
  - Non self-administered injectable medications; and
  - Outpatient diabetic supplies, such as glucose monitors, insulin pumps, infusion sets and reservoir syringes

Up to a maximum 90-day supply at any one time.

Palliative hospice care

We cover palliative hospice care as described in this section when provided by a Medicare or state certified hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. A patient-family unit is the patient and any family members who are caring for the patient. These services include acute, respite and home care to meet the physical, psychosocial, and special needs of

a patient-family unit during the final stages of illness and dying.

Palliative hospice care means medical services provided by a hospice care program that alleviate symptoms or afford temporary relief of pain but are not intended to affect a cure. If palliative hospice care is elected by the patient, then he or she is not eligible for any other benefits for active treatment of the terminal illness.

In order to qualify for palliative hospice care, the patient's physician must certify that the patient is terminally ill with a life expectancy of six months or less if the illness runs its normal course.

Levels of care

Palliative hospice care benefits are limited to the following treatment settings:

- Routine home care;
- Continuous home care;
- Inpatient respite care; and
- Inpatient hospice care.

Additionally, eligible charges for palliative hospice care include the following when provided under one of the previously listed levels of care:

- Durable medical equipment;
- Medications, including infusion therapy;
- Care by any member of the hospice interdisciplinary team; and
- Any other supplies required for the palliative hospice care.

If palliative hospice care is discontinued

If the patient elects to discontinue palliative hospice care before this palliative hospice care benefit has been exhausted, the patient will forfeit any remaining hospice benefit and we will not be obligated to pay for any additional palliative hospice care for that individual.

Exclusions

In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, expenses for the following services and supplies are not covered:

- Care that is not palliative;
- Services provided to other than the terminally ill patient, including charges for bereavement counseling for the covered employee, retiree, or covered dependents, except when provided and billed by the hospice care program;
- Pastoral and spiritual counseling;
- Services performed by family members or volunteer workers;
- Homemaker or housekeeping services, except by home health aides as ordered by a hospice treatment plan;
- Supportive environmental materials, including but not limited to, hand rails, ramps, air conditioners and telephones;
- Normal necessities of living, including but not limited to food, clothing and household supplies;
- Food services, such as "Meals on Wheels";
- Separate charges for reports, records or transportation;
- Legal and financial counseling services;
- Services and supplies not included in a hospice treatment program or not specifically set forth as a hospice benefit; and
- Services and supplies in excess of the stated maximums or services and supplies provided more than six months after the initial date of covered palliative hospice care, unless specifically approved by us.

Preauthorization

If palliative hospice care is provided by an agency other than a contracting agency, we strongly urge you to contact our Preauthorization Department before receiving such care. See "Preauthorization" subsection for a description of the preauthorization process.

Home infusion therapy

We cover home infusion therapy services and supplies as described in this section when they are medically necessary and are required for administration of a home infusion therapy regimen when ordered by a physician and provided by an accredited home infusion therapy agency.

Limited services

Home infusion therapy is limited to the following:

- Aerosolized pentamidine;
- Intravenous medication therapy;
- Total parenteral nutrition;
- Enteral nutrition (under certain circumstances);
- Hydration therapy;
- Intravenous/subcutaneous pain management;
- Terbutaline infusion therapy;
- SynchroMed pump management;
- IM/SC bolus/push medications; and
- Blood product administration.

Additionally, eligible charges includes only the following medically necessary services and supplies:

- Solutions, medications, pharmaceutical additives;
- Pharmacy compounding and dispensing services;
- Durable medical equipment;
- Ancillary medical supplies;
- Nursing services associated with:
  - Patient and/or alternative care giver training;
  - Visits necessary to monitor intravenous therapy regimen;
  - Emergency services;
  - Administration of therapy; and
- Collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy.

Preauthorization

If home infusion therapy is provided by an agency other than a contracting agency, we strongly urge you to contract our Preauthorization Department before receiving such therapy. See “Preauthorization” subsection for a description of the preauthorization process.

Limitations applicable to your plan

A few limitations (affecting benefits for medications, maternity care and nursing services, for instance) have already been listed. In addition, there are several general limitations that apply to your plan. They are described in the following paragraphs.

Treatment for chemical dependency and/or mental illness

The benefits for Mental Health Services under Samaritan Select have been improved to provide coverage for mental health conditions the same as any other medical condition, except as noted otherwise in this benefits booklet. This means that the inpatient and outpatient visit limitations no longer apply; however, all levels and types of services are still subject to medical necessity and preauthorization requirements. Residential treatment is limited to 45 days per calendar year.

Important information about accessing chemical dependency treatment and/or mental health services

Your provider must call Reliant Behavioral Health for preauthorization for inpatient or residential treatment of chemical dependency or metal illness. If a preferred provider renders services and preauthorization is not obtained, the preferred provider won't be paid by your plan for his or her services. You will not be responsible for these charges.

Outpatient treatment for chemical dependency and/or mental health treatment allows you to directly access provider and does not require preauthorization. However, your preferred provider must have an approved treatment plan in order to be paid if you have exceeded ten visits. Subsequent authorizations will be coordinated between the provider and Reliant Behavioral Health. If your provider does not submit and have an approved treatment plan, the provider will be responsible for his or her charges and you will not be billed for these services.

You may contact the Samaritan Select Customer Service Department at 800-569-4616 or 541-768-6900 to inquire if a preauthorization or treatment plan has been submitted and approved.

Definitions

The following definitions apply only to benefits for treatment of chemical dependency (including alcoholism) and/or mental illness.

Chemical dependency conditions means substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products or foods.

For **inpatient care,** a health facility means a hospital or other facility licensed for such care under state law or accredited by the Joint Commission on Accreditation of Hospitals, or the Commission on the Accreditation of Rehabilitation Facilities which provides American Society of Addition Medicine (ASAM) Level 4.0 acute treatment for alcoholism or drug addition, or a hospital with a psychiatric unit licensed to admit patients who require 24-hour acute care for mental illness.

Outpatient care means treatment under a program, which meets the standards, established by the Office of Mental Health and Addition Services or the Oregon Mental Health Division (or the equivalent agency, if services are provided outside Oregon) or by one of the following:

- A physician;
- A psychologist;
- A psychiatric mental health nurse practitioner;
- A licensed professional counselor or marriage and family therapist; or
- A residential/partial hospitalization/day care facility.

A **residential/partial hospitalization/day care facility** means a residential facility, hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the Office of Mental Health and Addiction Services or by the Oregon Mental Health Division in accord with ORS 743.556 (or the equivalent agencies, if the services are provided outside Oregon.)

An **emergency admission** is when a covered person's condition requires admission to a health care facility, residential facility or partial hospitalization/day care facility because of the risk of immediate harm to the covered person's health.

Samaritan Select will use the following criteria to determine the appropriate setting for care for the treatment of chemical dependency and/or mental illness:

- Expenses for inpatient health facility care will be covered only when the health facility records reflect that the patient's medical circumstances require 24-hour skilled nursing supervision and physician assessment meeting medical necessity or utilization management criteria;
- Expenses for residential/partial hospitalization/day care will be covered only when the facility records reflect that the patient requires intensive non-medical supervision, protection, assistance and treatment. In determining the patient's need for residential/partial hospitalization/day care, the following factors will be taken into consideration:
    - The patient's existing social, occupational and living situations which would adversely affect treatment provided on an outpatient basis;
    - Potential life-threatening risk to the patient or others
    - The patient's readiness and/or willingness to participate consistently in treatment; and
    - Other clinical issues in light of medical necessity and Utilization Management criteria.
- Expenses for outpatient mental health services will be covered when treatment is justified considering the patient's history and current medical, occupational, social and psychological situation and the overall prognosis.

An approved treatment plan for office-based care will be required in order to maintain benefits for outpatient treatment by a preferred provider exceeding ten visits. The frequency, duration and clinical plan are subject to review for medical necessity and overall utilization at periodic intervals. The patient's behavioral health provider should contact Reliant Behavioral Health for treatment plan review.

Preauthorization for the treatment of chemical dependency and mental illness

The following preauthorization procedure should be followed before you or your covered dependent receives treatment for chemical dependency and/or mental illness in order to decrease the possibility that benefits will be reduced or denied for inappropriate treatment setting or length of stay. The preauthorization requirements apply to all providers, including preferred, participating and non-participating providers

Prior to receiving treatment in:

- An inpatient program; or
- Any residential, or partial hospitalization or day treatment program

The patient's program or facility should contact Reliant Behavioral Health for preauthorization. If you or your covered dependent needs to speak with a Samaritan Select Customer Service Agent about a preauthorization or request for case management or help obtaining care, call 800-569-4616 or 541-768-6900.

The Preauthorization Department will then recommend the expected length of stay and the appropriate treatment setting. Residential treatment is limited to 45 days per 12-month period. Notification of our decision will be communicated by letter to the facility, the physician, and/or you or your covered dependent within two working days. The determination will be valid for 90 days from the date of the letter.

If an emergency admission must take place when our office is closed, please have the program contact us immediately at the earliest opportunity during regular business hours. Only emergency services will be reimbursed when preauthorization has not been obtained. We may require transfer to a facility/program, which is medically appropriate, based on the criteria given previously.

Benefits for chemical dependency

Benefits for the treatment of chemical dependency, including alcoholism, are subject to medical necessity and utilization

management criteria, and except in cases of emergencies, must be preauthorized and delivered in a chemical dependency licensed program in order to be paid. Benefits are subject to all applicable coinsurance, and/or co-payment amounts.

Benefits for mental illness
Benefits for mental illness are limited with regard to certain diagnoses (see GENERAL EXCLUSIONS Section) and with regard to residential or partial hospitalization. Otherwise, all benefits are subject to medical necessity or utilization management criteria, and may be subject to periodic review.

"Dual diagnosis" or benefits for both chemical dependency and mental illness
If, during a 12 consecutive-month period, a covered person receives covered services and supplies at a facility, or facilities licensed for both chemical dependency and mental illness treatment, benefits will be calculated on the basis that only one 45-day residential benefit period per 12 month will be allowed, regardless of diagnosis or combination of diagnosis.

Biofeedback therapy

Eligible charges for biofeedback therapy services are limited to treatment of tension headaches or migraine headaches.

Bariatric surgery

Surgical treatment of morbid obesity
The Plan will only cover the Roux-en-Y gastric bypass for the treatment of morbid obesity, and only when the criteria defined below are met. No other surgical procedures are covered by the Plan, including, but not limited to gastric banding, adjustable gastric banding, vertical banded gastroplasty, mini-gastric bypass (gastric bypass using a Billroth II type of anastomosis), distal gastric bypass (long-limb gastric bypass), biliopancreatic bypass, and biliopancreatic bypass with deudenal switch.

The Roux-en-Y gastric bypass may be covered for the treatment of morbid obesity when all of the following criteria are met:

1. BMI > 35 mg/k2 with a diagnosis of diabetes; or
   BMI > 40 mg/k2 with any comorbid condition; or
   BMI > 50 mg/k2 with or without comorbid conditions.
2. A 6-month work-up is completed that includes all of the following:
   - Dietary counseling and education; and
   - Medical evaluation; and
   - Psychological evaluation; and
   - Weight loss of > 5 percent over the 6 months.
3. Surgery is performed in a Center of Excellence recognized by Samaritan Select for the performance of such a procedure.
4. Preauthorization from Samaritan Select is obtained.

Transplants

Benefits for services and supplies (including medications) rendered in connection with a transplant, including pretransplant procedure such as ventricular assist devices (VADs), organ or tissue harvesting (donor costs), post-operative care (including antirejection medication treatment), and transplant related chemotherapy for cancers are limited as described here.

A **covered transplant** means a medically necessary transplant of one of the following organs or tissues only and no others:

- Heart;
- Heart/lung or lung;
- Liver;
- Kidney;
- Pancreas;
- Small bowel;
- Small bowel/liver;
- Autologous hematopoietic stem cells whether harvested from bone marrow or, peripheral blood when determined to be medically necessary, or from any other source, but only if required in the treatment of the following and no others:
  - Lymphoma;
  - Neuroblastoma;

- Acute lymphocytic leukemia;
- Acute myleogenous (nonlymphocytic) leukemia;
- Germ cell tumors of the testes, ovaries, mediastinum, and retroperitoneum;
- Ewing's sarcoma, high risk or relapsed;
- Hodgkin's disease;
- Medulloblastoma;
- Wilm's tumor; high risk, recurrent;
- Primitive neuroectodermal tumor;

- Allogeneic or syngeneic hematopoietic stem cells whether harvested from bone marrow or, peripheral blood when determined to be medically necessary, or from any other source, but only if required in the treatment of:
  - Aplastic anemia;
  - Acute leukemia;
  - Neuroblastoma;
  - Severe combined immunodeficiency;
  - Infantile malignant osteopetrosis;
  - Chronic myleogenous leukemia;
  - Lymphoma;
  - Wiscott-Aldrich syndrome;
  - Myelodysplastic syndrome;
  - Mucolipidoses;
  - Homozygous beta-thalessemia;
  - Myeloproliferative disorders;
  - Sickle cell anemia;
  - Kostmann's syndrome;
  - Leukocyte adhesion deficiencies;
  - X-linked lymphoproliferative syndrome;
  - Hodgkin's disease;
  - Wilm's tumor; high risk, recurrent; and
- Other transplants determined by us to be a medically necessary covered transplant since this booklet was issued.

Donor costs means all costs, direct and indirect (including program administration costs), incurred in connection with:

- Medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- Preserving it; and
- Transporting it to the site where the transplant is performed.

A **transplant** means a procedure or a series of procedures by which an organ or tissue is either:

- Removed form the body of one person (called the donor) and implanted in the body of another person (called a recipient); or
- Removed from and replaced in the same person's body (called a self-donor).

For purposes of this limitation, the term "transplant" includes a ventricular assist device (VAD) when used as a bridge to a heart transplant for a patient who is suffering from severe congestive heart failure, is in imminent risk of dying before a heart is available, and has been approved as a heart transplant candidate. In addition, in treatment of cancer, the term "transplant" includes any chemotherapy and related course of treatment, which the transplant supports.

For purposes of this limitation, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells), or cornea. These services are considered as non-transplant related and are covered elsewhere in the policy.

BENEFITS

Benefits for a Covered Transplant are payable as follows:

Facility benefits

We will waive any otherwise applicable coinsurance of the policy and pay 100 percent of the Contracted Amount for Facility Transplant Services:

- for covered persons residing in our service area, if a Covered Transplant is performed at a Contracting Transplant Facility; and
- for covered persons residing outside our service area, if a Covered Transplant is performed at a Contracting Transplant Facility nearest to the covered person's permanent residence.

Payment of the Contracted Amount at 100 percent does not accumulate towards the annual out-of-pocket maximum amount (the point at which coinsurance is no longer payable) under the policy.

We will pay 60 percent of reasonable charges towards the cost of Facility Transplant Services:

- for covered persons residing either inside or outside our service area if a Covered Transplant is performed at other than a Contracting Transplant Facility.

In either case, the percentage of payment (60 percent) will remain the same (no maximum out-of-pocket amount) throughout the calendar year. Payments at 60 percent do not accumulate toward the annual out-of-pocket maximum amounts under the policy.

The exception to the above facility benefits payment schedule is when the Covered Transplant is for a ventricular assist device (VAD), in which case we pay facility expenses according to the benefits for facilities under the policy.

Professional provider benefits

We will pay for Professional Provider Transplant Services according to the benefits for professional providers under the policy.

Benefits for donor costs

If the recipient or self-donor is covered under this policy, we will pay up to a maximum of $8,000 per Covered Transplant for Donor costs. If the donor is covered under this policy and the recipient is not, we will not pay toward Donor costs. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the policy if the donor or self-donor is covered under the policy.

Benefits for anti-rejection medications

For anti-rejection medications following the Covered Transplant, we will pay according to the benefits for prescriptions, if any, under the policy.

Limited waiver of policy maximum benefits

If the expenses of a Transplant at a Contracting Transplant Facility would cause a covered person to exceed his or her lifetime maximum benefit under the policy, we will waive the lifetime limit to the extent such expenses for Facility and Professional Provider Transplant Services and Donor Costs exceed the limit. This waiver will not apply to the cost of anti-rejection medications, a Transplant at a Non-contracting facility or to any subsequent Transplants.

PREAUTHORIZATION

All transplant procedures must be preauthorized for type of transplant and be medically necessary according to criteria established by us.

Preauthorization is a part of the benefit administration of the policy and is not a treatment recommendation. The actual course of medical treatment you or your covered dependent chooses remains strictly a matter between you or your covered dependent and your or your covered dependent's physician.

Preauthorization procedures

To preauthorize a transplant procedure, your or your covered dependent's physician must contact Samaritan Select's Preauthorization Department before the transplant admission. Preauthorization should be obtained as soon as possible after you or your covered dependent has been identified as a possible transplant candidate. See the Preauthorization provision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Only written approval from us on a proposed transplant will constitute preauthorization. If time is a factor, preauthorization will be made by telephone followed by written confirmation.

24-month exclusionary period

No benefits for Covered Transplants will be payable during the first 24 months an individual is covered under this policy except as follows:

- the 24-month exclusionary period will not apply if the covered person or self-donor has been continuously covered under this policy since birth; or
- we will reduce the duration of the 24-month exclusion period by the amount of you or your covered dependent's combined period of prior creditable coverage if the most recent period of creditable coverage ended within 63 days of your or your covered dependent's effective date of coverage under this policy. Creditable coverage means any of the following coverages:
- group coverage (including FEHBP and Peace Corps);
- individual coverage (including student health plans);
- Medicaid;
- Medicare;
- CHAMPUS/Tricare;

- Indian Health Service or tribal organization coverage;
- plan of a state, the U.S., a foreign country, or a political subdivision of one of these;
- state high risk pool coverage; and
- public health plans.

Prior creditable coverage is determined separately for each covered person. However, if benefits for the transplant would not have been payable under the previous coverage for any reason, no credits for such prior creditable coverage will be given under this policy toward the 24-month exclusion period. The covered person is responsible for furnishing evidence of the terms of transplant coverage under the previous coverage.

EXCLUSIONS

In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, we will not pay for the following:

- any transplant procedure that has not been preauthorized;
- any transplant performed outside of the United States;
- purchase of any organ or tissue;
- donor or organ procurement services and costs incurred outside the United States, unless specifically approved by us;
- donation related services or supplies provided to a covered donor if the recipient is not covered under this plan and eligible for Transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue;
- services or supplies for any Transplant not specifically named as covered including the Transplant of animal organs or artificial organs; and
- chemotherapy with autologous, allogeneic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered.

Miscellaneous services

Benefit amounts for medically necessary services not previously specified, such as Outpatient Rehabilitation, Injectibles and Therapeutic Injectibles, Cardiac Rehabilitation, Home Health and Skilled Nursing Facility services are subject to a 15 percent preferred or 30 percent non-preferred coinsurance amount. On the part time plan the coinsurance amounts are 20 percent preferred and 50 percent non-preferred.

General exclusions

We will not pay for any of the following:

Treatment prior to enrollment: Services or supplies you or a covered dependent received before you were first covered by this plan.

Treatment after insurance ends: Services or supplies you or a covered dependent receives after your insurance coverage under this plan ends. The only exception is when you or a covered dependent is in the hospital on the day the coverage ends, we will continue to pay toward eligible charges for that hospitalization until your discharge from the hospital or your benefits have been exhausted, whichever comes first.

Services provided by a member of your immediate family

Treatment not medically necessary: Service and supplies that are not medically necessary for the treatment of an illness or injury (see page 11).

Routine services and supplies: Services and supplies that are not medically necessary for the treatment of an illness or injury. These include:

- Routine tests and screening procedures, except as specifically listed;
- Treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care;
- Eye examinations, the fitting, provision or replacement of eyeglasses;
- Othoptics (eye exercises), visual aids and appliances and vision therapy;
- Telephone consultations, missed appointments, travel related expenses, completion of claim forms, or completion of reports requested by Samaritan Select in order to process claims;
- Self-help or training programs including, but not limited to court-ordered treatment, those to control weight or provide general fitness; also excluded are those programs that teach a person how to use durable medical equipment or how to care for a family member;
- Instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specially provided for under the "Outpatient Diabetic Instruction" benefit of this policy;
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education, such as air conditioners, humidifiers, air filters, whirlpools, hot tubs, heat lamps, or tanning lights;
- Maintenance supplies or equipment commonly used for purposes other than medical care;
- Private duty nursing, including ongoing hourly shift care in the home, or personal items such as telephones, televisions, and guest meals in a hospital or skilled nursing facility; and
- Speech therapy unless it is to improve or restore lost function due to illness or injury.

Surgery to alter refractive character of the eye: Surgical procedures which alter the refractive character of the eye, including, but not limited to, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism. Additionally, reversals or revisions of surgical procedures, which alter the refractive character of the eye and complications of all these procedures, are excluded.

Massage or massage therapy: Except as may be provided by a physical therapist or licensed chiropractor. Massage therapists are not eligible providers.

Orthopedic shoes or arch supports

Replacement or repair of a prosthetic device or of durable medical equipment necessitated by misuse or loss

Hypnosis, hypnotherapy and related services

Cosmetic/reconstructive services and supplies: Services and supplies (including medications) rendered for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery, except as follows:

- if the surgery is performed to correct a functional disorder or as the result of an accidental injury;
- if the surgery is performed for correction of congenital anomalies in children under age 18; or
- the surgery is related to breast reconstruction following a mastectomy necessary because of illness or injury in accordance with the Women's Health and Cancer Rights benefit.

"Cosmetic" means services and supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance or enhancing self-esteem.

"Reconstructive" means services, procedures and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Orthognathic surgery: Orthognathic surgery to change the position of a bone of the upper or lower jaw (except when medically necessary for the purpose of correcting a dysfunction).

Orthognathic surgery is not reimbursable as a benefit for temporomandibular joint (TMJ). Because TMJ is not directly related to the tooth or supporting services, we consider TMJ to be medical treatment. TMJ medical therapy services are limited to the examination, x-rays, physical therapy, TMJ splint, and surgical procedures appropriate for TMJ. Services directly related to the tooth or supporting structure are considered dental procedures even when provided to a patient diagnosed with TMJ. Examples of these services include occlusal equilibration, full mouth reconstruction, orthodontia services, and dentures.

Infertility medications, in vitro and in vivo fertilization: Including services related to or supporting in vitro fertilization, reversal of sterilization procedures, or GIFT and ZIFT procedures.

Dental examinations and treatments: Except as specially provided in the "Special Dental Care" and/or, if applicable, the "Covered Dental Expenses" or "Dental Benefits" section of the policy. For the purposes of this exclusion, the term "dental examinations and treatment" means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies rendered to repair defects which have developed because of tooth loss and services or supplies rendered to restore the ability to chew.

Physical exercise program: Even though they may be prescribed for a specific condition.

Mental health treatment, services and supplies are not covered for the following diagnostic categories, except as required in OAR 836-053-1405 and House Bill 2918:

- Paraphilias.
- Gender identity disorders in adults

Paraphilia: Services and supplies to diagnose rule out or treat Paraphilia as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

Gender identity disorder: Services and supplies to diagnose, rule out or treat gender identity disorders (including sex change procedures) as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders. However, treatment of children under age 19 for such diagnoses may be covered, but only when preauthorized by Samaritan Select. See the Preauthorization provision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Custodial care: Including routine nursing care and rest cures; and hospitalization for environmental change.

Behavior modification: Psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, wilderness experience programs, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

Counseling or treatment in the absence of illness: Including individual or family counseling or treatment for marital, social, behavioral, family, occupational, or religious problems; or treatment of "normal" transitional response to stress.

Experimental or investigational services: Treatments, procedures, equipment, medications, devices, and supplies (hereafter called services) which are, in our judgment, experimental or investigational for the specific illness or injury of the covered employee or covered family member receiving services are excluded. Services, which support or are performed in connection with the experimental or investigational services, are also excluded. For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services, which at the time they are rendered and for the purpose and in the manner they are being used:

- have not yet received final U.S. Food and Drug Administration (FDA) approval for other than experimental, investigational, |or clinical testing. However, if a medication is prescribed for other than its FDA approved use and the medication is recognized as effective for the use for a particular diagnosed condition, benefits for the medication when so used will not be excluded under this exclusion. To be considered effective for other than its FDA approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of the condition; or
- are determined by us to be in an experimental and/or investigational status. The following will be considered in making the determination whether the service is in an experimental and/or investigational status:
  - whether there is sufficient scientific evidence to permit conclusions concerning the effect of the services on health outcomes. "Scientific evidence" consists of:
    - well-designed and well-conducted clinical trails documenting improved health outcomes published in peer reviewed medical (or dental) literature. Peer reviewed medical (or dental) literature means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical (or dental) literature, the manuscript must actually have been reviewed by acknowledged experts before publication; and
    - evaluations by national professional medical (or dental) organizations, national consensus panels or other national technology evaluation bodies which have published a technology assessment or practice guideline based on peer reviewed medical (or dental) literature;
  - whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  - whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects;
  - whether the scientific evidence improves health outcomes as much or more than established alternatives;
  - whether any improved health outcome from the service is attainable outside investigational settings; and
  - the advice of participating professional providers medical (or dental).

Please note: An experimental or investigation service is not made eligible for benefits by the fact that other treatment is considered by your doctor to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

Service-related conditions: The treatment of any condition caused by or arising out of service in the armed forces of any country.

Work-related conditions: Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation. The only exception would be if you or your covered dependent is exempt from state or federal workers' compensation law.

Services otherwise available: A category that includes:

- services or supplies for which payment could be obtained in whole or in part if you or your dependent had applied for payment under any city, county, state, or federal law, except for Medicaid coverage;
- services and supplies you could have received in a hospital or program operated by a government agency or authority; unless reimbursement under this policy is otherwise required by law;
- charges for services and supplies you or your dependent

cannot be held liable for because of an agreement between the provider rendering the service and another third party payor which has already paid for such service or supply; and

- services or supplies for which no charge is made, or for which no charge is normally made in the absence of insurance.

Charges over usual and customary or reasonable: Any charge over the usual and customary or reasonable charge for services or supplies.

Standby charges when the provider renders no actual treatment to the patient

Benefits not stated: Services and supplies not specifically described as benefits under this policy.

Care of inmates: Services and supplies you or your covered dependent receives while in the custody of any state or federal law enforcement authorities or when in jail or prison.

Growth hormones: Growth hormone conditions other than growth hormone deficiency in:

- children or growth failure in children secondary to chronic renal insufficiency prior to transplant; or
- adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatment such as cranial irradiation, or surgery.

Growth hormone for the treatment of these listed conditions is covered when our medical policy criteria are met (preauthorization is required).

Impotence medications: Any medication therapy for the treatment of impotence regardless of cause.

Prescription medications: For prescription medication plan exclusions, see PRESCRIPTION MEDICATION PROGRAM Section of this document.

Benefits to be paid by other sources

Situations may arise in which health care expenses are also covered by a source other than Samaritan Select. If so, we won't provide benefits that duplicate the other coverage.

Motor vehicle coverage

In addition to liability insurance, most motor vehicle insurance policies are required by law to provide primary medical payments insurance and uncovered motorist insurance. Many motor vehicle policies also provide underinsurance coverage. Benefits for health care expenses are excluded under this policy to the extent that you or your covered dependent is able to or is entitled to recover form any type of motor vehicle insurance coverage.

Here are some rules, which apply with regard to motor vehicle insurance coverage:

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

Third-party liability

This provision applies when you or a covered dependent incurs health care expenses in connection with an illness or injury for which one or more third parties may be responsible. In that situation, benefits for such expenses are excluded under this policy to the extent you or your covered dependent receives a recovery from or on behalf of the responsible third party.

Here are some rules, which apply in these third-party liability situations:

- If a claim for health care expense is filed with us and you have not yet received recovery from the responsible person, we may advance benefits for covered expenses if you or your covered dependent agrees to hold, or directs you or your covered dependent attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the illness or injury. We will require that you or your covered dependent sign and deliver to us an agreement (called a trust agreement) guaranteeing our rights under this provision before we advance any benefits.
- If we pay benefits, we will be entitled to have the amount of the benefits we have paid separated from the proceeds of any recovery you or your covered dependent receives from or on behalf of the third party and held in trust for payment to us.

- We are entitled to the amount of benefits we have paid in connection with the illness or injury, regardless of whether you or your covered dependent has been made whole, from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you or your covered dependent, the third party's insurer, or any other insurance recovery. This is so regardless of whether:
  - the third party or the third party's insurer admits liability;
  - the health care expenses are itemized or expressly excluded in the third-party recovery; or
  - the recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the policy. The amount to be in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.
- If you or your dependent makes a recovery and fails to hold in trust for us the amount of paid benefits and to pay us that amount as required by this Third Party Liability provision, we may exclude future benefits for otherwise covered expenses for any illness or injury up to the amount of benefits we paid for the illness or injury caused by the third party.
- As long as you or your covered dependent has signed a trust agreement, we will allow a deduction of a proportionate share of the reasonable expenses of obtaining a recovery, such as attorney fees and court costs from the amount to be reimbursed to us.
- If you or your dependent incurs health care expenses for treatment of the illness or injury after recovery, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

The term "net recovery amount" is calculated as follows:

- the amount of recovery;

  plus

- the amount you or your covered dependent recovered from any other source such as other insurance as a result of the illness or injury;

  minus

- the difference between the total amount of third-party related health expenses incurred prior to the recovery and the benefits we paid before the recovery toward such expense;

  minus

- the amount you or your covered dependent reimbursed to us out of the recovery for benefits we paid before the recovery;

  minus

- the total costs paid by you or your covered dependent or on your or your covered dependent's behalf in obtaining the recovery such as reasonable attorney fees and court costs;

  shall equal

- the "net recovery amount."

Workers' compensation

This provision applies if you or your covered dependent has made or is entitled to make a claim for workers' compensation. Benefits for treatment of an illness or injury arising out of or
in the course of employment or self-employment for wages or profit are excluded under this policy. The only exception would be if you or your covered dependent is exempt from state or federal workers' compensation law.

Here are some rules, which apply in situations where a workers' compensation claim has been filed:

- You must notify us in writing within 5 days of filing a workers' compensation claim.
- If the entity providing workers' compensation coverage denies your claims and you have filed an appeal, we may advance benefits if you or your covered dependent agrees in writing to hold any recovery you or your dependent obtains form the entity providing workers' compensation coverage in trust for us according to the Third-Party Liability provision.

Medicare

In certain situations, this plan is primary to Medicare. This means that when you or your covered dependent is insured in Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are:

- when you or your spouse is age 65 or over and by law Medicare is secondary to your employer group health plan.
- when you or your covered dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and
- when you or your covered dependent is entitled to benefits under section 226(b) of the social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan.

In all other instances, we will not pay benefits toward any part of a covered expense to the extent the covered expense is actually paid or would have been paid under Medicare Part A or B had you or your covered dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare, we will not pay any part of expenses a Medicare-eligible covered member incurs from providers who have opted out of Medicare participation.

Coordination of benefits

Coordination of this *group contract's* benefits with other benefits

This Coordination of Benefits (COB) section applies when a *Member* 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.

Definitions relating to coordination of benefits

Plan

Plan means any of the following that provides benefits or *Services* for medical or dental care or treatment. 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.

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. 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 (1) or (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.

This plan

This 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 This 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 8.2.2 determine whether This plan is a Primary plan or Secondary plan when a *Member* has health care coverage under more than one Plan.

When This plan is primary, *We* determine payment for *Our* benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, *We* determine *Our* benefits after those of another Plan and may reduce the benefits *We* pay so that all Plan benefits do not exceed 100% of the total Allowable 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 *Member*. When a Plan provides benefits in the form of *Services*, the reasonable cash

value of each *Service* will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a *Member* 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 *Member* 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 *You* have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A closed panel plan is a Plan that provides health care benefits to *Members* primarily in the form of *Services* through a panel of providers that have contracted with or are 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.

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.

Order of benefit determination rules

When a *Member* 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:

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. 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 *Member* 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, This plan will not pay more than *We* would have paid had *We* been the Primary plan.

Effect on the benefits of this plan

When This plan is secondary, *We* 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 *Member* 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.

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 This plan and other Plans. *We* 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 This plan and other Plans covering a *Member* claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each *Member* claiming benefits under This plan must give *Us* any facts *We* need to apply this section and determine benefits payable.

Facility of payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, *We* 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 This plan. *We* 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*.

Right of recovery

If the amount of the payments made by *Us* is more than *We* should have paid under this COB section, *We* 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 *Member*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of *Services.*

Other claims recoveries

If we mistakenly make a payment for you or your covered dependent to which you or your covered dependent is not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefits from it, including a provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any of your covered dependents even if the mistaken payment was not made on that person's behalf.

We regularly engage in activities to identify and recover claims payments, which should not have been paid (for example, claims which are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit to your group's experience or the experience of the pool under which your group is rated all amounts that we recover, less our reasonable expenses in obtaining the recoveries.

How to file a claim

You must submit claims within one year of the time you receive services or supplies for us to pay benefits. Claims submitted beyond that date are not eligible for benefits. If circumstances beyond your control prevent you from submitting a claim within one year, the time period will be extended to 30 days beyond the time you reasonably could have submitted the claim.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Samaritan Select to the extent of the payment.

If we receive an inquiry regarding a properly submitted claim and we believe that you expect a response to that inquiry, we will respond to the inquiry within 30 days of when we first received it.

Hospital charges

If you or a dependent is hospitalized in one of our preferred hospitals, all you need to do is present your Samaritan Select identification card to the admitting office. In most cases, the hospital will bill us directly for the entire cost of the hospital stay. We'll pay the hospital and send you copies of our payment record. The hospital will then bill you for any of the charges that weren't covered by your Samaritan Select benefits.

Sometimes, however, the hospital will ask you, at the time of discharge, to pay amounts that might not be covered by your benefits. If this happens, you must pay these amounts yourself. We will, of course, reimburse you if any of the charges you pay are covered by your Samaritan Select.

When the hospital bills you

You may be billed for inpatient care you or a dependent receives in a non-participating hospital, and for outpatient care you receive in any hospital outside our service area. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following:

- The name of the covered person who was treated;
- Your name and your group and identification numbers;
- A description of the symptoms that were observed or a diagnosis; and
- A description of the services and the dates on which they were given.

If you have already paid for the services or supplies, please note that fact boldly on the billing and include a receipt.

The same procedure should be followed with bills for hospital or physician care you received outside the United States. Reimbursement will be made at the current rate of exchange at the time of service.

Physicians' charges

Your physician may bill charges directly to us. If not, you may send physician bills to us yourself. Be sure the physician uses his or her billing form and includes on the bill:

- The patient's name and the group and identification number;
- The date treatment was given;
- The diagnosis; and
- An itemized description of the services given and the charges for them.

If you have already paid the services and supplies, please note that fact boldly on the billing and include a receipt.

If the treatment is for an accidental injury, include a statement explaining the dates, time, place, and circumstances of the accident when you send us the physician's bill.

Filing a lawsuit

Any legal action arising out of this plan and filed against us by a covered person or any third party must be filed within three years.

Other health care charges

As we explained previously in the description of benefits, your Samaritan Select will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. Or you may send them to us at regular intervals—for example, once a month. **Again, if you have already paid for the services and supplies, please note that fact boldly on the billing and include a copy of your receipt.**

Prescription medication rebates

Samaritan Select participates in arrangements with medication manufacturers, which allow us to receive rebates based, among other things, on the volume of certain prescription medications purchased on behalf of covered individuals. Any rebates we receive from medication manufacturers will be credited back to PEBB's prescription program to help minimize future premium rate increase. Samaritan Select will withhold a percentage of the total rebate to cover our costs of collecting and administering the rebate program.

Appliances

By this term, we mean things such as artificial limbs, crutches, and wheelchairs. Bills for any of these items should include a complete description of the appliance and the reason it is needed. If your doctor wrote a prescription for the appliance, this should also be included with your claim. Always include your group and identification numbers and the patient's name.

Ambulance service

Bills for ambulance service must show where the patient was picked up and where he or she was taken. They should also show the date of service, the patient's name and group and member identification numbers. We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will pay you directly.

Claim determinations

Within 30 days of our receipt of a claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30 day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to act on the claim.
- When we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You must provide us with the requested information within 45 days of receiving the request for additional information. If we do not receive the requested information to process the claim within the 45 days we have allowed, we will deny the claim.

Explanation of benefits

We will report to you the action we take on a claim on a form called a Explanation of Benefits

If we deny all or part of a claim, the reason for our action will be stated on the Explanation of Benefits. The Explanation of Benefits will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your or your covered dependent's claim.

When benefits are available

The 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 supply is delivered to the patient.

There are two exceptions to this rule. One is when you are in the hospital on the day coverage ends. In this case, we will continue to pay toward eligible charges for the hospitalization until discharge from the hospital or until your benefits have been exhausted, whichever comes first.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Samaritan Select to the extent of the payment.

Out-of-area network services—National Access Program and MD Abroad

Samaritan Select participates in two participating provider networks, the National Access Program and MD Abroad. These networks benefit covered individuals who incur eligible charges outside our service area.

Under Samaritan Select, when you or a covered dependent receives covered health care services outside our service area from a provider who has a participating contract with National Access Program or MD Abroad the amount you pay for eligible charges is usually calculated on the lower of:

- The actual billed charges; or
- The negotiated price that National Access Program or MD Abroad passes on to us.

Often, this "negotiated price" will consist of a simple discount. But, sometimes it is an estimated price that factors into the actual price, expected settlements, withhold, or other non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average excepted savings with your provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) the price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

National Access Program

This Network is to be used when you do not have access to any type of medical professional that is within your Samaritan Preferred Provider Network within the USA. They will be sending you an ID card for their network soon after you become eligible with Samaritan Select. This card can be used in situations such as, but not limited to: when you are away on vacation, a child is away for school or other reasons or you or your covered spouse is away on business. Please contact Samaritan Select Customer Service for information about obtaining a Medical Home Provider for members living out of our service area.

To locate providers who participate within the National Access Program, please see the link on our web site, www.samaritanselect.com or call us for assistance at 541-768-6900 or 1-800-589-4616.

MD Abroad

Your participating provider network outside the USA is MD Abroad. Their logo is on the back of your Samaritan Select ID card for easy reference. To find a participating provider please call us for assistance.

Samaritan Select Customer Service agents can also help you access these programs. Please see the participating provider information under the Eligible Charges section of this document for further information.

Prescription medication program

The Samaritan Select prescription medication plan is administered through a nationwide network of participating pharmacies. Pharmacies that participate in this network submit claims electronically on-line, which are then processed according to your plan benefits.

Your Samaritan Select identification card identifies your medical program, and enables you to use the pharmacies that participate in this prescription medication program. If you would like a listing of the participating pharmacies, you may obtain one from your employer or from Samaritan Select, www.samaritanselect.com.

Prescription medication benefits replace policy benefits

The benefits of this medication plan replace those of the health plan, and any balance over the maximum amount available under this plan are not eligible for payment under any other provision of the plan.

Definitions

The definitions, which appear here, apply to this plan.

Generic medication means a prescription medication that is an equivalent medication to the brand name medication, is marketed as a therapeutically equivalent and interchangeable product and is listed in widely accepted references as a generic medication or is specified as a generic medication by us. **Equivalent medication** means the U.S. Food and Drug Administration (FDA) ensures that the generic medication must:

- have the same active ingredients;
- meet the same manufacturing and testing standards; and
- be absorbed into the bloodstream at the same rate and same total amount as the brand name medication.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication. If listings in widely accepted references are conflicting or indefinite about whether a prescription medication is a generic or brand medication, we will determine whether the prescription medication is a generic or brand name medication.

Brand name medication (single source brand) means a prescription medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Multi-source brand name medication means a brand name medication for which a generic medication may be substituted under the laws and regulations of the state in which the pharmacy dispensing the prescription is located.

Compound medication means two or more medications that are mixed together by the pharmacist. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend drug or one state restricted drug.

Coinsurance, for purposes of this prescription medication benefit, means any percentage amount you or your covered dependent must pay for a covered prescription medication. Coinsurance or co-payment amounts are assessed on each covered prescription medication claim (except for covered diabetic supplies).

Co-payment, for purposes of this prescription medication benefit, means any flat dollar amount you or your covered dependent must pay for a covered prescription medication. Coinsurance or co-payment amounts are assessed on each covered prescription medication claim (except for covered diabetic supplies).

Covered prescription medication expense means, for participating pharmacies, the amount we have agreed to pay participating pharmacies for a prescription medication. For non-participating pharmacies, covered prescription medication expense means the pharmacy's retail price for a prescription medication or the amount we would have paid a participating pharmacy for the same prescription medication, whichever is less. For mail order suppliers, covered prescription medication

expenses mean the amount we have agreed to pay mail order suppliers for a prescription medication.

Mail order supplier means a mail order pharmacy that has contracted with us to provide mail order services to covered employees and their covered family members.

Maintenance medication means a prescription medication that we have determined is intended to treat a chronic illness that requires medication therapy for more than 12 continuous months.

A **Pharmacist** means an individual licensed to dispense prescription medications and counsel a patient about how the medication works and its possible adverse effects.

A **Pharmacy** means any duly licensed outlet in which prescription medication are regularly compounded and dispensed.

A **Participating pharmacy** means a Pharmacy that had signed a participating pharmacy agreement with us and that submits claims electronically on-line at the time of dispensing.

Preferred medication list means a list comprised of generic medications and selected brand name medications, which is established, reviewed, and updated routinely by us.

Prescription medications are medications and biologicals that relate directly to the treatment of an illness or injury and cannot legally be dispensed without a prescription order, and that by law must bear the legend: "Caution—federal law prohibits dispensing without prescription," or which are specially designated by us. For purposes of this prescription medication benefit, prescription medications also include insulin and diabetic supplies, self-injectable medications, and compound medications. Although insulin and diabetic supplies do not require a prescription, they still require a prescription order
to be covered under this benefit.

Prescription order is a written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

Self-injectable medication means an outpatient injectable prescription medication intended for self-administration and approved by us for self-injection.

Therapeutic Tier this tier includes generic drugs that are intended to control selected medical conditions that have been targeted by Samaritan Health Plans.

How to use the prescription medication benefit

At a participating pharmacy, you or your covered dependent is required to present your identification card at the pharmacy in order to have the prescription medication claim submitted by the pharmacy electronically on-line. You or your covered dependent must pay your co-payment or coinsurance at the time of purchase.

If you or your covered dependent uses a non-participating pharmacy or you or your covered dependent uses a participating pharmacy but the claim is not submitted by the pharmacy electronically on-line, you or your covered dependent must pay for the medication. You then must complete a Direct Member Reimbursement Form and mail the form and receipt to us. How you will be reimbursed is described later.

PPO Plan

You pay a $5 co-payment for each generic prescription medication dispensed by a participating pharmacy. Each brand name medication on the preferred medication list dispensed by a participating pharmacy is subject to $15 co-payment. Each brand name medication not on the preferred medication list dispensed by a participating pharmacy is subject to the greater of a $50 co-payment or 50 percent of the cost of the medication—including the difference between the brand medication and generic medication if applicable.

Please note: No co-payment is applied for prescription orders for insulin or covered diabetic supplies.

PPO Part-Time and Retiree Plan

You pay a $10 co-payment for each generic prescription medication dispensed by a participating pharmacy. Each brand name medication on the preferred medication list dispensed
by a participating pharmacy is subject to a coinsurance of 20 percent of the covered prescription medication expense. Each brand name medication not on the preferred medication list dispensed by a participating pharmacy is subject to the greater of a $50 co-pay or a coinsurance of 50 percent of the

cost of the medication—including the difference between the brand medication and generic medication if applicable of the covered prescription medication expense. Once you have paid $1,000 out-of-pocket during the calendar year, your prescription medications will be paid in full.

Please note: No co-payment is applied for prescription orders for insulin or covered diabetic supplies.

All plans

The amount we cover and the amount you must pay depends on whether or not the pharmacy is a participating pharmacy.

- **Participating pharmacy**
  Eligible charges incurred at a participating pharmacy will be covered at 100 percent, less the co-payment or coinsurance, depending on which plan you are enrolled in, for a 34-day supply. You or your dependent need only present your identification card to the participating pharmacy and pay any co-payment or coinsurance at the time of purchase.
- **Non-participating pharmacy**
  You or your covered dependent must pay a non-participating pharmacy the full charge at the time of purchase and then submit a Direct Member Reimbursement Form for reimbursement. You will be reimbursed for covered expenses at our participating pharmacy rate, less the co-payment or coinsurance, depending on which plan you are enrolled in, for a 34-day supply. Payment will be sent directly to the covered employee or retiree.

Maximum out-of-pocket expense—PPO Part-Time and Retiree Plan only

The co-payment for prescription medications obtained for a participating pharmacy will be waived during the remainder of a calendar year in which your or your covered dependent's out-of-pocket expenses (co-payments) reach $1,000. The out-of-pocket maximum applies separately to each covered employee and their family members.

In order for the co-payment or coinsurance to be waived, you or your covered dependent must present your identification card to the participating pharmacy at the time of purchase and the participating pharmacy must submit the claim electronically on-line.

Expenses incurred at both participating pharmacies and non-participating pharmacies and expenses incurred for mail order prescription medications accumulate toward the out-of-pocket maximum.

Mail order benefit

Mail order is an optional method of obtaining maintenance medication under this prescription plan. Not all prescription medications are available from the mail order supplier and mail order benefits are available only when prescriptions are dispensed and the claim is submitted electronically on-line by the mail order supplier.

PPO Plan

Under this benefit, you or your covered dependent pays a co-payment of $12.50 for a 90-day supply each time a generic medication is dispensed or refilled by the mail order supplier. You or your covered dependent pays a co-payment of $37.50 each time a brand name medication from the preferred medication list is dispensed or refilled by the mail order supplier. Brand name medications not on the preferred medication list are subject to the greater of a $125 co-payment or 50 percent of the cost of the medication—including the difference between the brand medication and generic medication if applicable each time a prescription order is dispensed or refilled by the mail order supplier.

Please note: No co-payment is applied for prescription orders for insulin or covered diabetic supplies.

PPO Part-Time and Retiree Plan

Under this benefit, you or your covered dependent pays a co-payment of $25 for a 90-day supply each time a generic medication is dispensed or refilled by the mail order supplier. You or your covered dependent pays a co-payment of $62.50 each time a brand name medication from the preferred medication list is dispensed or refilled by the mail order supplier. Brand name medications not on the preferred medication list are subject to a $125 co-payment plus the difference between generic and brand for multi-source brands each time a prescription order is dispensed or refilled by the mail order supplier.

Please note: No co-payment is applied for prescription orders for insulin or covered diabetic supplies.

How to obtain mail order medications

To use the mail order plan, you or your covered dependent must send all of the following items to the mail order supplier at the address shown on the prescription mail order form obtained from your group:

- a completed prescription mail order form;
- the original prescription order; and
- the co-payment.

Refills
If a prescription order includes refills, they may also be obtained from the mail order supplier. You must complete the "refill" section on the back of the prescription order form, including the mail order supplier's prescription number, and send it to the mail order supplier along with the co-payment. Subsequent mail order prescription refills are available once you have used 75 percent of the supply from the previous mail order prescription.

Exceptions process for non-preferred brand-name medications

A formulary is a list of generic and preferred brand-name prescription drugs covered by your health plan.

What to do when your doctor prescribes a drug that isn't on the drug list:

- If your doctor prescribes a non-formulary drug to treat your condition, he or she can fax a request to 541-768-4294.
- Exceptions may be granted if formulary drugs have failed to treat your condition or have caused side effects that made you stop taking them. If an exception is granted, your co-payment is the preferred brand level.
- When you get an exception, the co-pay for the non-preferred drug will not apply to your deductible. (The co-pay of a preferred brand drug does apply to your deductible.)

Contact us for more information or call 541-768-5207.

Prescription medication plan limitations

The following limitations apply to the benefits of this prescription medication plan:

Maximum supply
The largest allowable quantity for most outpatient prescription medications purchased form a pharmacy is a 34-day supply. There are no exceptions to the maximum 34-day supply. The provider, however, may choose to prescribe some medications in smaller quantities or you or your covered dependent may wish to purchase some medications in smaller quantities. The amount payable is always based on each dispensing. Some examples of how the maximum 34-day supply works:

- if one tablet per day is prescribed, up to 34 tablets for a 34-day supply will be covered; or
- if one tablet per week is prescribed, up to four tablets for a 34-day supply will be covered.

The largest allowable quantity at one time per prescription medication purchased from the mail order supplier is a 90-day supply. The maximum quantity for self-injectable medications purchased from the mail order supplier is a 30-day supply. The provider, however, may choose to prescribe some prescription medications in smaller quantities or you or your covered dependent may choose to purchase some prescription medications in smaller quantities. The amount payable of how the maximum 90-day supply works:

- if one tablet per day is prescribed, up to 90 tablets for a 90-day supply will be covered; or
- if one tablet per week is prescribed, up to 12 tablets for a 90-day supply will be covered.

Maximum quantities
For certain medications, we have established a maximum quantity of medication allowed. This means that there is a limit for the amount of medication that will be covered during a period of time. We use information from the U.S. Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities.

Any amount over the established maximum quantity is not covered except if we determine the amount is medically necessary. The medication information must be provided by the health care provider who prescribed the medication in order to established maximum quantities include:

- Imitrex (used for migraines)—up to 12 doses every 34 days; and
- Diflucan 150 mg (antifungal agent)—up to 2 tablets every 34 days.

When you or your covered dependent take a prescription order to a participating pharmacy or requests a prescription medication refill and an identification card is used, the pharmacy will let you or your covered dependent know if a quantity limitation applies to the medication. To find out in advance whether a limit applies, contact Customer Service (number on the back of your identification card) or check our web site at www.samaritanselect.com.

Prescription refills

Refills obtained from a pharmacy or the mail order supplier are allowed after 75 percent of the supply from the previous prescription order is used. You or your covered dependent is responsible for the full cost of any prescription medications that are denied at the participating pharmacy for 'refill too soon' due to this quantity limitation.

Prescription medication plan exclusions

In addition to other exclusions of the group policy, the following exclusions apply to the benefits of this prescription medication plan:

Non-prescription medications

Medications that by law do not require a prescription order and which are not included in our definition of prescription medications.

Contraceptives

Certain contraceptive prescription medications and devices are covered under this prescription medication plan; however, Norplant, surgically inserted contraceptive devices, IUDs, Depo-Preovera and other non self-administered contraceptives are not. These may be covered under other previsions of
the plan.

Administration or injection of medications

Prescription medications with no proven therapeutic indication

Prescription medications that were not medically necessary

Immunization agents, biological sera, blood or blood plasma

Vitamins and fluoride
Except those that by law require a prescription order.

Injectable prescription medications
Except those defined as self-injectable. Excluded are all injectable prescription medications administered in a physician's office, hospital, outpatient facility, or skilled nursing facility.

Prescription medications dispensed in facility
Prescription medications dispensed to a covered person while a patient is in a hospital, skilled nursing facility, nursing home or other health care institution.

Prescription medications for weight loss or treatment of obesity
Including, but not limited to amphetamines.

Prescription medications for treatment of infertility

Growth hormones
Growth hormone conditions other than growth hormone deficiency in:

- Children or growth failure in children secondary to chronic renal insufficiency prior to transplant; or
- Adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatment such as cranial irradiation, or surgery.

Growth hormone for the treatment of these listed conditions is covered when our medical plan criteria are met (preauthorization is required). See the preauthorization prevision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Prescription medications for the treatment of impotence regardless of cause

Medications prescribed for cosmetic purposes

Tretinoin (i.e. Retin-A) for covered employees and covered family members age 24 or over

Medications prescribed for treatment of hair loss regardless of cause
Including but not limited to topical minoxidil.

Renova

Medications prescribed for hair removal regardless of cause

Including but not limited to Vaniqa.

Newly approved prescription medications
Prescription medications newly approved by the Federal Food and Drug Administration (FDA) may be excluded for up to 18 months after the approval date. This list of newly approved prescription medications currently excluded is provided to participating pharmacies and is available to covered members on our web site (www.samaritanselect.com) and in paper form from us.

Refills needed for stolen, lost, spilled or destroyed prescription medications

Prescription medications for which claims are submitted 12 months or more after the date of purchase

Any medication not specifically described as a benefit under this prescription medication benefit

Preauthorization

There are certain prescription medications, which must be preauthorized before they will be considered for payment under this prescription medication benefit. Preauthorize and preauthorization mean the process by which we determine that a prescription medication is medically necessary, based on the information provided to us, before it is dispensed. Coverage for medications that have been preauthorized begins on the date we determine that the medication is medically necessary. Any medication that requires preauthorization that

is purchased without such preauthorization or is purchased before the date that we determined the medication was medically necessary is not covered under this prescription medication plan, even if purchased from a participating pharmacy.

Participating providers, including participating pharmacies, are notified which prescription medications require preauthorization. The medical information necessary to determine medical necessity for medications that require preauthorization must be provided by the health care provider who is prescribing the medication.

If you or your covered dependent take a prescription order to a participating pharmacy and show your identification card, the pharmacy will let you or your covered dependent know if preauthorization is necessary for the prescription medication. To find out in advance whether a prescription medication requires preauthorization, contact Customer service (number on back of your identification card) or check our web site at www.samaritanselect.com. For more information on preauthorization, including how we are bound to cover an authorized service or supply, please see Preauthorization under the ELIGIBLE CHARGES Section.

General medication plan provisions

Right to examine records
Samaritan Select can require you or your covered dependent to authorize any participating pharmacy furnishing prescription medications under this plan to make available to us information relating to a prescription order or any other records we need in order to approve a claim payment.

Group coverage benefits responsible
This plan is provided only under group coverage. There is no conversion privilege, nor is this plan available under any nongroup plan.

We are not responsible
We cannot be held liable for any claim or damages connected with illness or injuries suffered by you or your covered dependent arising out of the use of any prescription medication or insulin.

Right to deny benefits or prescription orders
We reserve the right to deny benefits for any medication prescribed or dispensed in manner contrary to normal medical practices. In addition, a pharmacy need not dispense a prescription order, which, in the pharmacist's professional judgment, should not be filled.

Utilization review program
Included as part of this prescription medication benefit is a medication utilization review program. Utilizing a database of information on each of your prescription medication claims, the program alerts a dispensing pharmacist of potential conflicts in medication therapy, duplicate prescription medications, and overuse before you obtain the prescription medication. Prescription medication claims submitted electronically on-line by a participating pharmacy are analyzed with your active medication profile for potential medication problems. Claims determined to be excessive utilization and therefore not medically necessary will be denied.

Recovery of benefits paid by mistake

If we mistakenly make a payment for you or your covered dependent, or on you or your covered dependent's behalf, we have the right to recover the payment from you or your covered dependent, not the pharmacy. This includes the right to deduct the amount paid by mistake from future benefits we provide to you, even if the mistaken payment was not made on that person's behalf.

General medication plan provisions

The provisions described in the WHAT KIND OF SERVICES AND SUPPLIES ARE COVERED and ELIGIBILITY sections of this plan also apply to this prescription medication plan.

Member appeals and grievance process

This procedure is designed to keep lines of communication open and to provide an opportunity for mutual understanding among our covered individuals, providers, and us. Grievances and appeals are promptly directed to appropriate individuals within Samaritan Select so action can be taken quickly, and on an informal basis if possible. Final decisions may be decided by an independent physician (not associated with Samaritan Health Services), as explained below under the third step in the grievance and appeals process.

If you believe a plan, action, or decision of ours is incorrect, please contact our Customer 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 verbal or written appeal with us within 180 days of the claim 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 concerns regarding a decision, action, or statement by your provider, we encourage you to discuss these concerns with the provider. If you remain dissatisfied after discussing your concern with your provider, you may file a grievance with our Customer Service Department. However, if you would prefer to discuss your concern with us rather then your provider, please contact our Customer Service Department.

First step—Filing a grievance

There are three internal steps to our grievance and appeal process. The first level of review is filing a grievance. You must file your grievance within 180 days of the claim denial or other action, giving rise to the grievance by writing us a letter, filling out a grievance form, or by contacting our Customer Service Department by phone. Within five business days of receiving a grievance, we will send you or your representative an acknowledgment letter outlining your issues as well as advising you of your rights. Within 30 calendar days, you or your representative will receive a written decision from our grievance coordinator. However, if more extensive review is needed, we will notify you of the delay within the initial 30-day period and the decision will come within 45 days.

Second step—Filing first appeal

If you remain dissatisfied after the initial grievance review, you have the right to file an appeal verbally or in writing within 180 days of receiving a response from us. Within five business days of receiving the appeal, we will send you or your representative an acknowledgment letter. Someone not previously involved in your case will review your issue. For clinical issues, a practitioner that specializes in your medical condition or procedure will be involved in the review of your appeal. A panel of representatives will evaluate your case and your appeal coordinator will notify you or your representative of the decision in writing. The written decision will be sent:

- for appeals of preservice (preauthorization) claims, within 14 calendar days of our receiving your appeal;
- for appeals of postservice claims denied as investigational, within 30 calendar or 20 working days of our receiving your appeal; or
- for appeals of all other postservice claims, within 30 calendar days of our receiving your appeal.

Third step—Voluntary appeal (may include external review)

The third and final level of internal appeal may be filed verbally or in writing within 180 days of our latest decision. If you decide to proceed with the voluntary third step in the appeals process, your internal review will be determined by us by an appeal panel comprised of reviewers not previously involved in your case. Within five business days of receipt, we will send you or your representative, in writing, of the decision within 30 days of our receiving your appeal.

This final internal appeal, which is voluntary on your part, may qualify for a further voluntary appeal, external review. External review is available only for certain types of appeals described below and will be decided by an independent physician (not associated with Samaritan Health Services). Appeals qualifying for external appeal must first have been considered through internal review, unless you and we have mutually agreed to waive that requirement.

External review

We will allow a covered individual, by applying to us, to obtain an independent and external review as long as the appeal is:

- an adverse determination based on medical necessity (cosmetic or non-participating provider services, for example);
- an adverse determination for treatment determined as experimental or investigational; or
- for purposes of continuity of care (no interruption of an active course of treatment)

You should know that in order to have the appeal decided by external review, you or your covered dependent must:

- sign a waiver granting the independent review physician

access to medical records; and

- have exhausted all other appeals and grievance opportunities under this plan unless, with your consent, we waive this requirement.

You are not responsible for the costs of the independent review.

A written response to your appeal will be sent to you or your representative within 20 days of the independent review physician receiving the appeal. **We are bound by the decision made by the independent review, even if it conflicts with our definition of medically necessary.**

If you want more information regarding external review, please contact our Customer Service Department at 541-768-6900, or toll-free at 800-569-4616.

Expedited procedure

In the event you or your physician reasonably believes that a utilization management decision is clinically urgent and that application of the regular appeal time frames to the review of our denial of preauthorization of a service could jeopardize your life, health, or ability to regain maximum function, you or your representative may request an Expedited Appeal. Expedited Appeal also is available if a physician with knowledge of your medical condition concludes that application of the regular appeal time frames to the review of our denial of preauthorization of a service would subject you to severe pain that cannot be adequately managed without the disputed service. The appeal request must be made verbally or in writing within 180 days after you receive notice of the initial written preauthorization denial, should state the need for a decision on an expedited basis, and must include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to Samaritan Select. A verbal notice of the decision will be provided to you or your representative as soon as possible after the decision, but no later than one working day or seventy-two hours of receipt of the request for the first level expedited appeal, whichever is sooner, and a written notice will be provided within one working day of providing the verbal notification.

For information about our grievance and appeals process, you may contact out Customer Service Department at (Corvallis/Albany area) 541-768-6900, or toll-free at 800-569-4616, or you can write to our Customer Service Department at the following address:

Samaritan Select
Customer Service Department
PO Box 1310
Corvallis, OR 97339

Disclosure statement — Patient Protection Act

In accordance with Oregon law (Senate Bill 21, known as Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform you and your covered dependents about the benefits and policies of this health insurance plan.

What are my rights and responsibilities as a member of Samaritan Select?

No one can deny you or your covered dependent the right to make your own choices. As a member, you and your covered dependent have the right to:

- be treated with dignity and respect
- impartial access to treatment and services without regard to race, religion, gender, national origin, or disability;
- know the name of the physicians, nurses, or other health care professionals who are treating you or your covered dependent;
- the medical care necessary to correctly diagnose and treat any covered illness or injury;
- have providers tell you or your covered dependent about the diagnosis, the treatment ordered, the prognosis of the condition, and instructions required for follow-up care;
- know why various tests, procedures, or treatments are done, who the persons are who give them, and any risks you or your covered dependent needs to be aware of;
- refuse to sign a consent form if you or your covered dependent does not clearly understand its purpose, cross out any part of the form you or your covered dependent doesn't want applied to care, or have a change of mind about treatment you or your covered dependent previously approved;
- refuse treatment and be told what medical consequences might result from you or your covered dependent's refusal;
- be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain you or your covered dependent's right to make health care decisions, in advance, if you or your covered dependent becomes unable to make them);

- expect privacy about care and confidentiality in all communications and in you or your covered dependent's medical records;
- expect clear explanations about benefits and exclusions;
- contact our Customer Service Department and ask questions or present complaints; and
- be informed of the right to appeal an action or denial and the related process.

You and your covered dependents have a responsibility to:

- tell the provider you or your covered dependent is covered by Samaritan Select and show an identification card when requesting health care services;
- be on time for appointments and to call immediately if there is a need to cancel an appointment or if you or your covered dependent will be late. You or your covered dependent is responsible for any charges the provider makes for "no shows" or late cancellations;
- provide complete health information to the provider to help accurately diagnose and treat you or your covered dependent's condition;
- follow instructions given by those providing health care to you or your covered dependent;
- review this health care booklet to make sure services are covered by the plan;
- make sure services are preauthorized when required by this plan before receiving medical care;
- contact our Customer Service Department if you or your covered dependent believes adequate care is not being received;
- read and understand all materials about your health benefits and make sure family members that are covered under this plan also understand them;
- give an identification card to your covered family members to show at the time of service; and
- pay any required co-payments at the time of service.

How do I access care in the event of an emergency?

If you or your covered dependent experiences an emergency situation, you or your covered dependent should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether your or your covered dependent's condition requires emergency treatment, you or your covered dependent can always call the provider for advice. The provider is able to assist you or your covered dependent in coordinating medical care and is an excellent resource to direct you or your covered dependent to the appropriate care since he or she is familiar with your or your covered dependent's medical history.

How will I know if my benefits change or are terminated?

If you are covered through a group plan at work, your employee benefits administrator will let you know if and when your benefits change. In the event your group plan terminates and your employer does not replace the coverage with another group plan, your employer is required by law to advise you in writing of the termination.

What happens if I am receiving care and my doctor is no longer a contracting provider?

When a professional provider's contact with us ends for any reason, we will give notice to those covered that we know, or should reasonably know, are under the care of the provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than 10 days after the provider's termination date or 10 days after the date we learn the identity of an affected covered individual, whichever is later. The exception to our sending the notice is when the professional provider is part of a group of providers and we have agreed to allow the provider group to provide continuity of care notification to those covered.

When continuity of care applies

If you or your covered dependent is undergoing an active course of treatment by a preferred professional provider and benefits for that provider would be denied (or paid at a level below the benefits for an out-of-area provider) if the provider's preferred contract with us is terminated or the provider is no longer participating in our preferred provider network, we will continue to pay plan benefits for services and supplies

Rescinding coverage

We may rescind your and/or your covered dependent's coverage under this plan from the beginning as never effective or deny a claim at any time for fraud, material misrepresentation, or concealment by you or your covered dependent in obtaining or attempting to obtain benefits under this plan or for knowingly aiding or permitting such actions by another.

If we rescind coverage as described above, we will retain premiums paid as liquidated damages and reserve the right to recover from you or your covered dependent the benefits paid as a result of such wrongful activity that are in excess of the premium payments. In addition, we may deny future enrollment of the group or covered person under any Samaritan plan or the plan of any of our subsidiaries for a period of up to five years.

provided by the professional provider as long as:

- you or your covered dependent and the professional provider agree that continuity of care is desirable and you or your covered dependent requests continuity of care from us;
- the care is medically necessary and otherwise covered under the plan;
- you or your covered dependent remains eligible for benefits and covered under the plan; and
- the plan has not terminated.

Continuity of care does not apply if the contractual relationship between the professional provider and us ends in accordance with quality of care provisions of the contract between the provider and us, or because the professional provider:

- retires;
- dies;
- no longer holds an active license;
- has relocated outside of our service area;
- has gone on sabbatical; or
- is prevented form continuing to care for patients because of other circumstances.

How long continuity of care lasts

Except as follows for pregnancy care, we will provide continuity of care until the earlier of the following dates:

- the day following the date on which the active course of treatment entitling you or your covered dependent to continuity of care is completed; or
- the 120th day after notification of continuity of care.

If you or your covered dependent becomes eligible for continuity of care after the second trimester of pregnancy, we will provide continuity of care for that pregnancy until the earliest of the following dates:

- the 45th day after the birth;
- the day following the date on which the active course of care treatment entitling you or your covered dependent to continuity of care is completed; or
- the 120th day after notification of continuity of care.

The notification of continuity of care will be the earliest of the date we or, if applicable, the provider group notifies you of your or your covered dependent of the right to continuity of care, or the date we receive or approve the request for continuity of care.

Complaint and Appeals: If I am not satisfied with my health plan or provider what can I do to file a complaint or get outside assistance?

To voice a complaint with us, simply follow the process outlined in the MEMBER APPEALS AND GRIEVANCE PROCESS Section of this booklet, including, if applicable, information about filing an appeal to be reviewed by an independent physician without charge to you.

You and your covered dependents also have the right to file a complaint and seek assistance from the director of the Department of Consumer and Business Services (DCBS). You or your covered dependent can write to the Director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

Or call: 503-947-7984

Or e-mail: dcbs.insmail@state.or.us

What are your preauthorization and utilization review criteria?

Preauthorization, also known as prior authorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact our Prior Authorization Department at the phone number on the back of your identification card, see the PREAUTHORIZATION Section of the handbook, or ask you or your covered dependent's provider for a list of services that need to be preauthorized. Many types of treatment may be available for certain conditions. The preauthorization process helps the provider work together with you or your covered dependent, other providers, and us to determine the treatment that best meets your or your covered dependent's medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, preauthorization is you and your covered dependents' assurance that medical services will not be denied because they are not medically necessary.

Utilization review is a process in which we examine services you receive to ensure that they are medically necessary—appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of medically necessary in the DEFINITIONS Section of this booklet.

Let us know if you or your covered dependent would like a written summary of information that we may consider in our utilization review of a particular condition or disease. Simply call the Customer Service phone number on the back of your identification card.

How are important documents (such as my medical records) kept confidential?

We have a written plan to protect the confidentiality of health information. Only employees who need to know in order to do their jobs may access your personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing you or your covered dependent's coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from you or your representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of

utilization management, quality assurance, or peer review.

My neighbor has a question about the plan that he has with you and doesn't speak English very well. Can you help?

Yes. Simply have your neighbor call our Customer Service Department at the number on his or her identification card. One of our representatives will coordinate the services of an interpreter over the phone. We can help with sign language as well as spoken languages.

What additional information can I get from you upon request?

The following documents are available by calling a Customer Service representative:

- Rules related to our medication formulary, including information on whether a particular medication is included or excluded from the formulary and information on what medications require preauthorization from Samaritan Select.
- Provisions for referrals for specialty care, behavioral health services, and hospital services, and how you may obtain the care or services.
- A copy of our annual report on complaints and appeals.
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration.
- A description of our efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care.
- Information about our prior authorization and utilization review procedures.

What other source can I turn to for more information about your company?

The following information regarding the health benefit plans of Samaritan Health Services is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of our health promotion and disease prevention activities.
- Samples of the written summaries delivered to plan holders.
- An annual summary of grievances and appeals.
- An annual summary of utilization review policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, write to:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310

Or call: 503-947-7984

Or e-mail: dcbs.insmail@state.or.us

Eligibility

The Public Employees' Benefits Board (PEBB) Eligibility Rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

See the PEBB eligibility rules for more information.

Notice of termination

In the event the group plan is terminated and the insurance coverage is not replaced by the group, we will mail to the group a notice of termination. It is then the duty of the group to send each covered employee or retiree a notice of the termination. The notice will explain the covered employee's or retiree's rights to continuation or conversion of coverage under federal and/or state law. Our notice to the group will be mailed within 10 working days of the plan termination date or, in the event of termination due to nonpayment of premium, the notice will be mailed within 10 working days of expiration of the grace period for payment of premium under the plan. If we fail to give notice as required in this provision, we will waive the premiums and the plan will continue in full force and effect from the end of the 10-day period to the date notice is received by the group. In this case, the period in which a covered person has to apply for continuation or conversion will begin on the date the group receives notice.

Continuation coverage rights under COBRA

COBRA notice

This notice includes important information about your rights and obligations under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under federal COBRA law, the State of Oregon is required to offer covered employees and family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage"). This Continuation Coverage is offered at group rates when coverage under the medical plan would otherwise end due to certain qualifying events. This notice is intended to inform all plan participants, in a summary fashion, of your potential future options and obligations under the Continuation Coverage provisions. Should an actual qualifying event occur in the future, the COBRA Administrator will send you additional information and the appropriate election notice at that time.

The Plan Administrator is the Public Employees' Benefit Board (PEBB) located at 775 Court Street NE in Salem, Oregon. You can contact PEBB at 503-373-1102 or 1-800-788-0520. COBRA continuation is administered by a third party administrator (TPA).

Continuation coverage

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. Continuation Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses or domestic partners of employees and dependent children of employees may be qualified beneficiaries.

Qualifying events for covered employee

If you are an employee, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. A reduction in you hours of employment; or
2. Your employment ends for any reason.

Qualifying events for covered spouse or domestic partner

If you are the covered spouse or domestic partner, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Death of the employee;
2. Termination of the employee's employment or reduction in the employee's hours of employment;
3. The employee becomes enrolled in Medicare (Part A, Part B, or both); or
4. Divorce or legal separation from the employee or termination of your domestic partnership.

Qualifying events for covered dependent children

Your dependent children become qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Death of the employee;
2. Termination of employee's employment or reduction in the employee's hours of employment;
3. The employee becomes enrolled in Medicare (Part A, Part B, or both);
4. The employee's divorce or legal separation, or termination of a domestic partnership; or

5. The child ceases to qualify as a dependent child under PEBB eligibility.

Important employee, spouse or domestic partner, and dependent notification requirements

Under the law, the employee or family member is responsible to inform the agency's payroll/personnel office or benefits office within 60 days of the following qualifying events:

1. A divorce;
2. A legal separation;
3. A termination of domestic partnership; or
4. A dependent child losing dependent status under PEBB eligibility.

If this notification is not mailed within the 60 days, rights to Continuation Coverage will be forfeited.

Employer notification requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of the date coverage ends.

Election period

When the agency payroll/personnel or benefits office receives notification that one of these events has occurred, they will notify the COBRA Administrator. The Administrator will notify qualified beneficiaries by first class mail of their right to choose Continuation Coverage within 14 days. Under COBRA provisions, each individual covered on the active group plan on the day before the qualifying event or any newborn or adopted children added to your plan during the COBRA time period has the right to elect Continuation Coverage. You, your spouse or domestic partner can elect continuation coverage for any combination of individuals who would otherwise lose coverage.

Under the law, you have 60 days from the date you would lose coverage due to a qualifying event or the date on your notification letter; whichever is the later date, to elect Continuation Coverage. The Public Employees' Benefit Board (PEBB) Eligibility Rules allow an employee or covered family member to change their plan choices upon experiencing a qualifying event. This means that not only is the employee or family member given the right to continue coverage under COBRA, but may also choose any medical plan at the time of the COBRA election. If a qualified beneficiary does not elect Continuation Coverage within this period, rights to continue medical insurance will end.

If you choose Continuation Coverage, PEBB is required to offer you coverage that is identical to the coverage provided under the group plan to similarly situated active employees and family members. Should coverage change or be modified for active employees, then the change or modification will be made to your coverage as well. COBRA participants will also be offered an annual open enrollment period. This open enrollment period allows participants to change plans and add or delete eligible dependents. If you add family members, the family members will not be COBRA qualified beneficiaries and will not be permitted to make independent COBRA elections.

Length of Continuation Coverage