Samaritan Choice Plans

SUMMARY OF MATERIAL MODIFICATIONS & NOTICE OF REQUIRED DISCLOSURES

This document provides changes made to your Medical, Pharmacy and Vision benefits effective January 1, 2017. If you do not have a 2015 Samaritan Choice Medical and Pharmacy Member Handbook, 2015 Samaritan Choice Vision Member Handbook, or your 2015 and 2016 Summary of Material Modifications (SMM), please call our Customer Service Department at 541-768-4550; Toll-free at 1-800-832-4580; TTY 1-800-735-2900. You can also visit our member portal for an electronic copy at MyHealthPlan.samhealth.org.

KEEP THIS NOTICE WITH YOUR 2015 and 2016 SAMARITAN CHOICE PLANS' MEDICAL & PHARMACY AND VISION PLAN DOCUMENTS. THIS IS A LEGAL PART OF YOUR MEMBER HANDBOOK.

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

Summary of benefits: Samaritan Choice Wellness Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Wellness and High-Deductible). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefits and Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
PREVENTIVE SERVICES (these services are not applied to your deductible & some services will not have a cost share)		
Well baby care	$0	30%
Routine physicals	$0	30%
Routine gynecological exams	$0	30%
Immunizations	$0	30%
Colorectal screening	$0	30%
PROFESSIONAL SERVICES		
Primary care visits [1]	$25	30%
In-office procedures	$25	30%
Specialist visits	$35	30%
In-office procedures	$35	30%
Urgent care center visits	$20	$20
Surgery professional (at hospital or ASC)	$60	30%
PRIMARY CARE HOME (PCH) SERVICES *-In-Network WELLNESS PLAN Only.* All eligible services that are rendered and billed by assigned Primary Care Homes (PCH) are 100% covered by the Samaritan Choice Wellness Plan Option. Eligibility criteria will apply. 100% coverage only if the Wellness program identifies that the member would benefit from these services. You may be required to participate in these programs. No cost shares or deductibles apply.		
Primary Care Home (PCH) Services	$0	Not covered
CARE COORDINATION SERVICES - In Network providers only for asthma, diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD). No cost shares or deductibles apply.		
Office visit	$0	30%
EDUCATION SERVICES - In Network providers only. Regular cost-sharing is assessed for all out –of- network providers. Does not apply to deductibles.		
Office visit for specified education services	$0	30%
Heart Health and Wellbeing Program - In Network WELLNESS PLAN services only. All eligible services that are rendered and billed by assigned Program Coach are 100% covered only to those who are eligible for this Program. No cost shares or deductibles apply.		
Cardiac rehabilitation services	$0	Not covered
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	$130/day, up to 5 days or $650	30%
Inpatient rehabilitative care	$130/day, up to 5 days or $650	30%
Skilled Nursing Facility care	$0	30%
Bariatric surgery/ gastric banding (Lap band) surgery [2]	$5,000	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in office procedures)	$150	30%
Emergency department visits (unless admitted to hospital)	$100	$100
Radiology	$0	30%
Lab	$0	30%

Summary of benefits: Samaritan Choice Wellness Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Wellness and High-Deductible). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefits and Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
VALUE-BASED COST SERVICES – In-Network only (Specified surgical procedures & high tech imaging)		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis) [3, 4]	$400 (does not apply to member OOP maximum or deductible)	30%
High tech imaging services [3, 4] (CT scans, MRIs and PET scans)	$200 (does not apply to member OOP maximum or deductible)	30%
CHEMICAL DEPENDENCY		
Office visits	$35	30%
Inpatient care	$130/day, up to 5 days or $650	30%
Residential programs	30%	30%
MENTAL HEALTH		
Office visits	$15	30%
Inpatient care	$130/day, up to 5 days or $650	30%
Residential programs	30%	30%
OTHER COVERED SERVICES		
Physical therapy	$25	30%
SHS Physical Therapist providers	$20	NA
Occupational therapy	$25	30%
Speech therapy	$25	30%
Allergy injections (most) [5]	$5	30%
Injectables and other drugs administered other than orally (when rendered in the office) [5]	15%	15%
Ambulance, ground	30% after $100 co-pay	30% after $100 co-pay
Ambulance, air [6]	Plan pays up to $6,000 limit/incident	Plan pays up to $6,000 limit/incident
Durable Medical Equipment (DME)	30%	50%
Home health care	$25	30%
Hospice	$0	30%
Hearing aids	Plan pays up to $1,000 limit/year No limit for children age 20 and under	Plan pays up to $1,000 limit/year No limit for children age 20 and under
Acupuncture	$35	35%
Chiropractic [7]	$25, Plan pays up to $850 limit per year	30% Plan pays up to $850 limit per year
Panniculectomy [8]	50%	Not covered

[1] Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.
[2] Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit or deductibles.
[3] Value-based Co-pay does not apply if coded as Emergency Services. Cost shares will default to normal benefit for Emergency Services.
[4] Value-based co-pays do not count towards annual deductibles and Out-of-Pocket (OOP) Limits. Other applicable co-payment or coinsurance must be separately paid as applicable (e.g. office visits, lab services, etc.).
[5] Contact Customer Services at 541-768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance levels and applicable services.
[6] Air ambulance does not apply to Out-Of–Pocket (OOP) Limit.
[7] Chiropractic benefit only includes manipulation and exams. This benefit does not include x-rays, labs, other radiology or other services that are not considered to be a manipulation treatment.
[8] Panniculectomy coinsurance does not apply to Out-Of-Pocket Limit or deductible. Services will only be covered when gastric bypass has been rendered by contracted provider.

Summary of benefits: Samaritan Choice High Deductible Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Wellness and High-Deductible Plans). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefits and Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
PREVENTIVE SERVICES (these services are not applied to your deductible & some services will not have a cost share)		
Well baby care	$0	30%
Routine physicals	$0	30%
Routine gynecological exams	$0	30%
Immunizations	$0	30%
Colorectal screening	$0	30%
PROFESSIONAL SERVICES		
Primary care visits [1]	$20	30%
In-office procedures	$20	30%
Specialist visits	$35	30%
In-office procedures	$35	30%
Urgent care center visits	$20	$20
Surgery professional (at hospital or ASC)	$50	30%
Office visit for specified education services	$0	30%
EDUCATION SERVICES - In Network providers only. Regular cost-sharing is assessed for all out –of- network providers. Does not apply to deductibles.		
Office visit for specified education services	$0	30%
HOSPITAL / INPATIENT SERVICES		
Inpatient room and board	$100/day, up to 5 days or $500	30%
Inpatient rehabilitative care	$100/day, up to 5 days or $500	30%
Skilled Nursing Facility care	$0	30%
Bariatric surgery/ gastric banding (Lap band) surgery [2]	$5,000	Not covered
OUTPATIENT SERVICES		
Outpatient surgery (does not include in office procedures)	$150	30%
Emergency department visits (unless admitted to hospital)	$100	$100
Radiology	$0	30%
CT, PET scan	$0	30%
MRI	$150	30%
Lab	$0	30%
MENTAL HEALTH		
Office visits	$35	30%
Inpatient care	$100/day, up to 5 days or $500	30%
Residential programs	30%	30%

Summary of benefits: Samaritan Choice High Deductible Plan

The tables below summarize the benefits for the Samaritan Choice Medical Plan options (Wellness and High-Deductible Plans). Please refer to other sections of this document for a detailed description of your benefits. This summary does not replace your Summary of Benefits and Coverage document. **Important Notice: All services apply to the deductible unless otherwise specified.**

Service	In Network: *Member Pays*	Out of Network: *Member Pays*
CHEMICAL DEPENDENCY		
Office visits	$35	30%
Inpatient care	$100/day, up to 5 days or $500	30%
Residential programs	30%	30%
OTHER COVERED SERVICES		
Physical therapy	$25	30%
SHS Physical Therapist providers	$20	NA
Occupational therapy	$25	30%
Speech therapy	$25	30%
Allergy injections (most) [3]	$5	30%
Injectables and other drugs administered other than orally (when rendered in the office) [3]	10%	10%
Ambulance, ground	30% after $100 co-pay	30% after $100 co-pay
Ambulance, air [4]	Plan pays up to $6,000 limit/incident	Plan pays up to $6,000 limit/incident
Durable Medical Equipment (DME)	30%	50%
Home health care	$15	30%
Hospice	$0	30%
Hearing aids	Plan pays up to $700 limit/year No limit for children age 20 and under	Plan pays up to $700 limit/year No limit for children age 20 and under
Acupuncture	$35	35%
Panniculectomy [5]	50%	Not covered

[1] Primary Care Provider visit is defined as services provided by a Pediatrics, Family Medicine, and Internal Medicine or OB-GYN provider.
[2] Bariatric Surgery and Gastric Banding (Lap band) surgery co-pays do not apply to Out-of-Pocket Limit or deductible.
[3] Contact Customer Services at 541-768-4550 or 1-800-832-4580 to determine your co-pay or coinsurance levels and applicable services.
[4] Air ambulance does not apply to Out-Of–Pocket (OOP) Limit.
[5] Panniculectomy coinsurance does not apply to Out-Of-Pocket Limit or deductible. Services will only be covered when gastric bypass has been rendered by contracted provider.

Samaritan Choice Plans

2017 PRIOR AUTHORIZATION LIST

Coverage of certain medical services and surgical procedures require Samaritan Choice Plans' (SCP) written authorization before the services are performed. Your provider may request prior authorization by phone, fax, or mail. If for any reason your provider will not, or does not, request prior authorization for you, you must contact SCP yourself. In some cases, additional information or a second opinion may be required before authorizing coverage.

THE FOLLOWING MEDICAL SERVICES AND SURGICAL PROCEDURES REQUIRE PRIOR AUTHORIZATION BY SAMARITAN CHOICE PLANS:

- Clinical Trials
- Durable Medical Equipment (DME) including insulin pumps, prosthesis, oxygen and oxygen supplies, with line item prices over $1,000 in rental or purchase fees or rentals over 3 months.
  - Continuous Glucose Monitors (CGM) and CGM supplies
- Elective procedures or services (for the following):
  - Bariatric surgery
  - Genetic testing except standard prenatal testing and Non-Invasive Prenatal Testing (NIPT)
  - Neck and back surgery (inpatient, outpatient and those done as in-office procedures)
  - Panniculectomy
  - Sclerotherapy
  - Uvulopalatopharyngoplasty
- Hospitalization for dental procedures including ASC
- Inpatient hospital care*, including:
  - Mental health services
  - Exception: Labor and delivery
  - Exception: Newborn less than 5 days
- Potentially cosmetic, reconstructive and/or experimental surgery and services
- Radiological services (for the following):
  - Capsule/wireless endoscopies
  - Computer Axial Tomography (CAT) scans
  - Magnetic Resonance Imaging (MRI)
  - Positron Emission Tomography (PET) scans
  - Virtual Colonoscopy
- Residential services for mental health and substance abuse treatment including detoxification
- Skilled Nursing Facility (SNF)
- Therapeutic abortion
- Transplants, including evaluation (except corneal)

* Emergency Services will not require prior authorization in accordance with Patient Protection and Affordability Care Act. We request notification of any emergency admissions or observation stays that exceed 48 hours in order to ensure that all of the member's care is appropriately coordinated.

Medically appropriate: 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 based on credible scientific evidence that is published in peer-reviewed, medical literature generally recognized by the relevant medical community; Physician Specialty Society recommendations; and, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Samaritan Choice Plans reserves the right to review or otherwise deny services that are not medically necessary. Prior authorization is not guarantee of payment.

🡻 🡻 🡻 THIS DEFINITION REPLACES LANGUAGE IN THE DEFINITIONS SECTION ON PAGE 3 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER 🡻 🡻 🡻

Reconstructive surgery Designed to improve *function* after injury or disease. Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, transgender services, or medical conditions. Services may require prior authorization.

🡻 🡻 🡻 THIS SECTION REPLACES LANGUAGE IN THE OUT-OF-POCKET LIMITS AND DEDUCTIBLES SECTION ON PAGES 4-5 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

Out-of-pocket limits and deductibles

This is only a brief summary of benefits. Please refer to the additional information throughout this Plan Document for further explanations of your benefits including limitations and exclusions.

Out-of-pocket limits

Samaritan Choice Wellness Plan	**Your out-of-pocket max**
Per member	$3,000
Per family	$6,000
Samaritan Choice High-Deductible Plan	**Your out-of-pocket max**
Per member	$3,150
Per family	$6,300
Samaritan Choice Pharmacy	**Your out-of-pocket max**
Per member	$4,000
Per family	$8,000
•Preferred and non-preferred out-of-pocket max limits are combined.	

Your annual out-of-pocket limit

This plan has an out-of-pocket limit to protect you from excessive medical expenses. The Summary of Benefits shows your plan's annual out-of-pocket limit. If you incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to these benefits.

Expenses for the following DO NOT count toward your out-of-pocket limit:

- Prescription drugs (separate out-of-pocket limit applies)
- Charges over usual, customary, and reasonable amounts
- Benefits paid in full (for example, vision hardware, air ambulance)
- Incurred charges that exceed amounts allowed under this plan
- Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan.
- Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims)
- Bariatric and Gastric banding surgery co-pays
- Value-based service co-pays
- Panniculectomies
- Other services that are specifically called out in this document

Samaritan Choice Wellness Plan: Out-of-pocket max

- Preferred & Non-Preferred providers: $3,000 per person/ $6,000 per family per calendar year.
- Once the applicable out-of-pocket limit has been met, this plan will pay 100% of covered charges for services at the applicable preferred or non-preferred benefit level for the rest of that calendar year.

- The pharmacy benefit has a separate out-of-pocket limit of $4,000 per person and $8,000 per family.

Samaritan Choice High Deductible Plan: Out-of-pocket max

- Preferred & Non-Preferred providers: $3,150 per person/ $6,300 per family per calendar year.
- Once the applicable out-of-pocket limit has been met, this plan will pay 100% of covered charges for all services at the applicable preferred or non-preferred benefit level for the rest of that calendar year.
- The pharmacy benefit has a separate out-of-pocket limit of $4,000 per person and $8,000 per family.

Deductible This is the portion of covered benefit costs each member is obligated to pay before Samaritan Choice Plans will provide benefits. The deductible amount for individuals and families is listed in your Member Benefit Summary. No family will have to satisfy more than the Family Maximum Deductible each Calendar Year.

The following DO NOT count toward deductible:

- SOME Preventive services do not apply to your deductible obligation.
- Bariatric surgery -services
- Value based service co-pays
- Panniculectomies
- Other services outlined in this document

Information about your deductible

Plan	Maximum lifetime benefit	Annual individual deductible	Annual family deductible
Wellness Plan option	None	$250	$750
High Deductible Plan option	None	$2,500	$7,500
Your Preferred and Non-preferred deductibles are combined.			

🡻 🡻 🡻 THIS SECTION WAS REMOVED FROM THE SAMARITAN CHOICE BASIC PLAN SUMMARY OF BENEFITS SECTION ON PAGES 8-10 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

The Samaritan Choice Basic Plan Summary of Benefits section has been removed as the Basic Plan is no longer an option for the 2017 plan year.

🡻 🡻 🡻 THIS LANGUAGE IS BEING ADDED TO UPDATE THE PLAN BENEFITS SECTION STARTING ON PAGE 24 OF YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

CHIP (Complete Health Improvement Program) is a lifestyle medicine program scientifically proven to help people improve their blood pressure, cholesterol, triglycerides, blood sugar, BMI, sleep, resilience and depression. The class integrates optimal nutrition, exercise and behavioral psychology principles and tools to help participants achieve their health goals. Program materials will be reimbursed up to $150. Services outside of program materials will be covered if they meet all plan provisions and are directly billed by a provider. All plan provisions apply for services billed, and will be reimbursed in accordance to the benefit that is applied.

🡻 🡻 🡻 THE LANGUAGE IN THESE BENEFITS REPLACES LANGUAGE IN THE PLAN BENEFITS SECTION ON PAGES 24-25 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER 🡻 🡻 🡻

Cosmetic and/or reconstructive surgery services that are considered to be, or are potentially cosmetic and/or reconstructive **must be prior authorized**. Surgery may be covered under the following circumstances:

- Reconstructive surgery to primarily correct a functional disorder
- Breast reconstruction following medically necessary mastectomy, including reconstruction of the opposite breast to achieve cosmetic symmetry.
- Reconstructive surgery necessitated by an accidental injury or is medically approved by the plan.
- Surgery to correct a facial scar or defect resulting from medically necessary surgery that was covered or would have been covered, under this plan.
- Surgery to correct a scar or defect resulting from surgery for cancer.
- Surgery to correct a congenital defect.

For cosmetic and/or reconstructive surgeries, the following additional limitations apply:

- Only one (1) attempt at reconstruction is covered following initial injury or surgery.
- The reconstruction must be undertaken within 18 months of the original injury or surgery. This limit does not apply to children who sustain injury prior to their full physical developmental age or who are born with congenital defects requiring reconstructive surgery.

Additional reconstructive surgery that is medically necessary to correct a functional disorder resulting from the initial surgery, may be covered.

Diabetic equipment is covered, generally classified as durable medical equipment with a 30% coinsurance when in-network, unless otherwise stated. **Continuous glucose monitors require prior authorization** and will have a 10% coinsurance when in-network for the Wellness plan and a 30% coinsurance when in-network for the High Deductible Plan. The following diabetic equipment is covered with a $0 cost share: diabetic pumps, glucose monitors, and test strips. Diabetic *supplies* are considered a separate benefit from Diabetic equipment. See the **Diabetic supplies section** of this document for more information.

Education services this benefit, previously called Education and Coaching services, is $0 co-pay for office visits for Education services opened to any In Network Provider. Regular cost sharing remains for non-preferred providers.

🡻 🡻 🡻 THIS LANGUAGE REPLACES LANGUAGE IN THE EXCLUDED SURGERIES AND PROCEDURES PORTION OF THE BENEFIT EXCLUSIONS SECTION ON PAGE 32 IN YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER 🡻 🡻 🡻

This plan does not cover the following surgeries and procedures:

- **Any treatment or services provided by an alternative medicine provider are not covered under this plan, unless specified in this document;**
- Cosmetic or reconstructive surgery except as specified in the **Plan benefits section**;
- Abdominoplasty;
- Treatment for infertility, including artificial insemination, in vitro fertilization, or GIFT procedures;
- Surgery to reverse voluntary sterilization;
- Routine foot care such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails **unless, the patient has diabetes, peripheral vascular disease, or recurrent infections**;
- Surgical procedures that 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;
- Treatment to augment or reduce the upper or lower jaw, except when necessary due to an injury;

- Temporomandibular joint (TMJ) or myofascial pain treatment, advice, or appliances;
- Services for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures;
- Transplants, except as specified in the **Plan benefits section**;
- Eye surgeries to improve vision such as, Lasik;
- Myeloablative high dose chemotherapy, except when the related transplant is covered;
- Massage or massage therapy, even if it is part of a physical therapy program;
- Services, supplies, testing or treatment for sterility, infertility, impotency, frigidity, or sexual inadequacy;
- Custodial care, including routine nursing care and rest cures and hospitalization for environmental change.
- Planned births in the home.

🡻 🡻 🡻 THIS LANGUAGE IS BEING ADDED TO UPDATE THE PLAN DISCLOSURES SECTION ON PAGE 44 OF YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

Nondiscrimination Notice (Section 1557 of the Affordable Care Act (ACA))

Discrimination is Against the Law
Samaritan Choice Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Samaritan Choice Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Samaritan Choice Plans:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact Customer Service at 541-768-4550, Toll Free: 800-832-4580, TTY: 1-800-735-2900.

If you believe that Samaritan Choice Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Appeals and Grievances, P.O. Box 1310, 541-768-4550, TTY: 1-800-735-2900, Fax: 541-768-9765, SHPOGrvcTeam@samhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

🡻 🡻 🡻 THIS SECTION: MULTI-LANGUAGE INTERPRETER SERVICES IS BEING ADDED TO UPDATE PAGE 52 OF YOUR SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

MULTI-LANGUAGE INTERPRETER SERVICES:

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-832-4580 (TTY: 1-800-735-2900).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-4580 (TTY: 1-800-735-2900).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-832-4580（TTY：1-800-735-2900）。

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-832-4580 (TTY: 1-800-735-2900).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-4580 (ATS : 1-800-735-2900).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-832-4580 (TTY: 1-800-735-2900).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-4580 (TTY: 1-800-735-2900).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-832-4580 (TTY: 1-800-735-2900) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-4580 (телетайп: 1-800-735-2900).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-832-4580 (TTY: 1-800-735-2900) पर कॉल करें।

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-832-4580 (TTY: 1-800-735-2900).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-832-4580 (TTY: 1-800-735-2900).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-832-4580 (TTY: 1-800-735-2900).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-832-4580 (TTY: 1-800-735-2900).

Japanese: **注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-832-4580（TTY:1-800-735-2900）**まで、お電話にてご連絡ください。**

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-832-4580 (TTY: 1-800-735-2900).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-832-4580 (TTY: 1-800-735-2900).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-832-4580 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2900).

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។   ចូរ ទូរស័ព្ទ 1-800-832-4580 (TTY: 1-800-735-2900)។

Farsi (Persian):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-832-4580 (TTY: 1-800-735-2900) تماس بگیرید.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-832-4580 (رقم هاتف الصم والبكم: 1-800-735-2900).

🡻 🡻 🡻 THIS SECTION REFLECTS BENEFIT CHANGES THAT ARE NOT CURRENTLY IDENTIFIED IN THE SAMARITAN CHOICE PLANS' 2015 MEDICAL & PHARMACY BENEFITS MEMBER HANDBOOK 🡻 🡻 🡻

The $150 Samaritan Choice Wellness Plus benefit is ending on December 31, 2016. The new flexible incentive option will being on January 1, 2017. Employees and COBRA members who were former employees that are Samaritan Choice Wellness Plan members can receive $150 by earning points for completing a variety of health-related activities, such as an annual physical exam, a dental preventive exam, and a flu shot.

Points will be tracked and managed online at the My Wellness website where employees now manage their biometric screening and health assessment, and view their health risk score and report. Employees who earn 20 points during 2017 will qualify for the $150 incentive, which will be taxable.

Samaritan Choice Plans
Samaritan Health Plans Operations
PO Box 336
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choice.samhealthplans.org
Myhealthplan.samhealth.org