

HEALTH INSURANCE MARKETPLACE

MEMBER HANDBOOK

AND DISCLOSURE INFORMATION 2027

CommunityHealthChoice.org
713.295.6704 | 1.855.315.5386

COMMUNITY HEALTH CHOICE

COMMUNITY_IND_2027_HANDBOOK

IMPORTANT PHONE **NUMBERS**

1.855.315.5386	MEMBER SERVICES 8:00 a.m. – 5:00 p.m., Monday – Friday, (excluding federal-approved holidays.) PROVIDER SERVICES (Eligibility/Authorizations/Benefits/Claims)	713.295.6704

Information is available in English and Spanish or call COMMUNITY to get an interpreter.

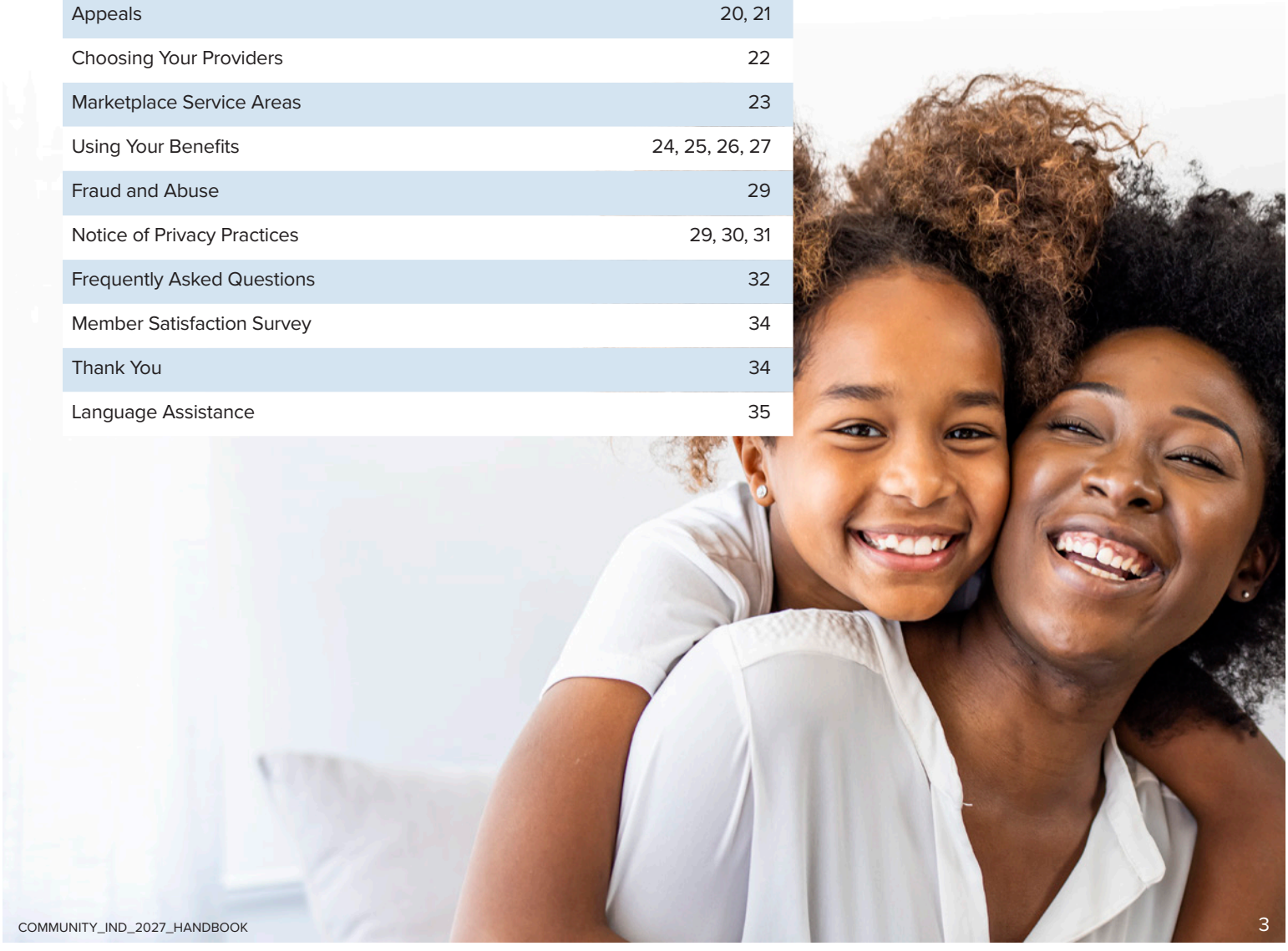
7-1-1	TDD for Hearing-Impaired	
1.800.835.2362	Teladoc Teladoc telehealth services are available to Members enrolled in all Marketplace plans	
1.833.955.1528	Medical Advice Line	
1.866.333.2757	Pharmacy (Navitus Health Solutions)	Navitus.com
1.800.552.6694	Mail-Order Pharmacy Portal Prescription Services – a subsidiary of The Kroger Co.	Ppsrx.com (Kroger Mail Order)
1.844.293.1752	Vision (Evolve Vision)	visionbenefits.envolvehealth.com
1.855.539.5881	Behavioral Health/Substance Abuse Services	CommunityHealthChoice.org
1.877.888.0002	Waste, Abuse or Fraud Hotline	

Write or visit us at:
Community Health Choice
4888 Loop Central Drive, Suite 600
Houston, TX 77081
www.CommunityHealthChoice.org

In case of an emergency call 9-1-1 or go to the nearest emergency room.

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WELCOME TO **COMMUNITY HEALTH CHOICE**

Thank you for choosing Community Health Choice (Community).

Community is a **LOCAL**, non-profit Health Maintenance Organization (HMO) that genuinely **CARES** for and **SERVES** the community. With Community, you have a **TRUSTED** friend who opens doors to high quality health care, and makes the process **EASY**.

Community Health Choice is a Qualified Health Plan and therefore demonstrates compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Member Handbook

This handbook is a guide to help you get the health care you need and is a companion piece to the **Evidence of Coverage** and the Summary of Benefits and Coverage. Inside you will find important information about your coverage. All documents are online at www.CommunityHealthChoice.org and can be mailed to you upon request. Contact Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

Evidence of Coverage

An Evidence of Coverage is a document that a Texas-licensed HMO uses to describe the services and benefits to which a covered person is entitled. It describes all terms, conditions, exclusions, and limitations that apply to your plan. A **Schedule of Benefits** is part of the Evidence of Coverage and summarizes benefit information and Member cost shares or covered services.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) gives information about health plan benefits and coverage in a simple way. This document will help you better understand your coverage and allow you to easily compare different coverage options. It summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Member Services

If you have any questions about your coverage, you may call Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

Our hours are 8:00 a.m. – 5:00 p.m., Monday – Friday, excluding state-approved holidays. We speak English and Spanish, or we can get an interpreter who speaks your language. We also make this handbook available in Braille and large print. Community Member Services can help you:

- Understand your benefits
- Choose or change a Primary Care Provider
- Find a specialist
- Send you a new Member ID card
- Solve complaints or problems

New Technology Assessment

We provide for care that is shown to be safe and useful. We review new healthcare treatments. We review new procedures. The review uses up-to-date health data. This is called New Technology Assessment. We decide whether to pay for these things. This review means we pay when safety and value is clear. You may ask us to review new technology.

Utilization Management Decisions

Community follows guidelines to determine what health care services we cover. This is called utilization management. We know how important it is that we make the right decisions for your care. Community follows three principles when we make these decisions:

1. Our decisions are based only on whether or not:
   - The care and services are appropriate.
   - It is a covered benefit.
2. We do not reward doctors or anyone else for denying coverage.
3. We do not give incentives to doctors or anyone else to encourage them to make decisions that would mean you would get less care than you need.

Quality Improvement

Our Quality Improvement Department helps Community provide you access to high quality care. If you want more information about our Quality Improvement Program, please contact Member Services toll-free at 1.855.315.5386.



DEFINITIONS

Copayment/Coinsurance

A specified dollar amount or amount expressed as a percentage you are obligated to pay toward covered expenses of certain benefits specified.

Deductible

The amount you and/or your family must incur for covered services and are responsible for before any copayment amounts. A Deductible will only apply if you have a consumer choice health benefit plan.

Formulary

A list of preferred prescription drugs that are approved for coverage by Community's pharmacy benefit program. It includes brand name and generic drugs approved by the U.S. Food and Drug Administration (FDA).

HMO

A Health Maintenance Organization (HMO) arranges for or provides a healthcare plan to enrollees on a prepaid basis.

Network

Phycisians, hospitals, and other healthcare providers who have a contract with Community to provide services at a negotiated rate of payment for our Members.

Non-Network

Physicians, Hospitals and other Health Care Professionals who do not have a contract with Community to provide services at a negotiated rate of payment for our Members.

Off-Exchange

Health plans purchased directly from Community, completely outside HealthCare.gov.

On-Exchange

Health plans purchased through HealthCare.gov.

Out-of-Pocket Maximum

The most you pay for covered services each year. Once reached, the plan pays 100% for most covered services for the rest of the year.

Over-the-Counter (OTC) Medication

Medicines you can buy without a prescription.

Primary Care Provider

A primary care provider (PCP) is trained to manage all of your health conditions. Your PCP plays many roles: primary caregiver, healthcare advisor and consultant, coordinator of specialty care, patient advocate, and medical home. PCPs can be:

- Family/General Practitioners (doctors who treat patients of all ages)
- Internists (doctors who treat adults and may have a subspecialty)
- Pediatricians (doctors who treat children)
- Obstetricians/Gynecologists (OB/GYNs) (doctors who treat pregnant women and women who are not pregnant)

Prior Authorization

A determination by Community or its designee that a service or prescriptive drug is medically necessary prior to being provided. Some healthcare services, prescription drugs or medical equipment require you or your Provider to obtain approval or prior authorization before receiving services, except in an emergency.

Referral

A referral is a consultation for evaluation and/or treatment of a patient requested by one doctor to another doctor.

Specialist

A physician specialist focuses on a specific area of medicine or group of patients. Examples of specialists include:

- Cardiologists
- Dermatologists
- Surgeons

Step Therapy

A type of prior authorization required for some high-cost drugs.

COVERED **SERVICES**

Covered healthcare expenses must be considered medically necessary and, in some cases, require prior authorization by Community. A list of covered services and services requiring prior authorization is available at https://provider.communityhealthchoice.org/resources/prior-authorization-information/.

The following is a summary of covered benefits. Although listed below, benefits are subject to the exclusions and limitations and Member cost share as described in the Evidence of Coverage. For details on each covered service, please review the Evidence of Coverage or contact Member Services for the list at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

- Acquired brain injury services
- Dental services as a result of dental injuries
- Diabetes services
- Durable medical equipment and medical supplies
- Emergency services
- Emergency transportation services
- Healthcare treatment facility services (hospital services)
- Healthcare practitioner services home health care
- Hospice care
- Mental health services (including chemical dependency services)
- Maternity care and newborn services
- Outpatient services (rehabilitative and habilitative services and autism spectrum disorder services)
- Prescription drugs
- Preventive care services
- Reconstructive surgery
- Skilled nursing facility and rehabilitative services
- Transplant services, transplant transportation, and lodging
- Urgent care
- Vision Services for Children (or members 18 years old or under)

Does My Coverage Include Hospitals?

Community Health Choice offers in-network hospitals that are close and convenient. You can view our network of hospitals at www.CommunityHealthChoice.org. Talk to your PCP or Specialist and ask where he/she has privileges. Ask your practitioner about which hospital is best for your condition. It is important to use an in-network hospital when seeking care. In case of an emergency, go to the nearest hospital Emergency Room.

Pharmacy Services

Pharmacy services are provided by Navitus. Their network includes more than 64,000 independent and chain retail pharmacies with national chains such as Walgreens, HEB, Kroger, Walmart, and others. A complete list of participating pharmacies is available on their website at www.Navitus.com or through Navitus Member Services toll-free at 1.866.333.2757. You can call Navitus 24-hours a day, seven days a week. The Navitus Member Guide is on our web site at www.CommunityHealthChoice.org under the Plans & Benefits section.

A mail-order program is included in your pharmacy benefit. Benefits are provided through Postal Prescription Services (a subsidiary of Kroger Co). By participating in the mail-order program, you can have up to a 90-day supply mailed directly to your home or office. To enroll online, go to Ppsrx.com and choose “Mail Order Pharmacy” or call Kroger toll-free at 1.800.552.6694.

Prescription Drug Coverage

Community has a preferred drug list that provides details and level copays for each covered drug. You are required to pay all deductibles (if applicable) or copays for the level copay amount listed on the Summary of Benefits.

You may request a copy of this list from our Member Services Department by calling 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org. A copy is also available online at Formulary – Premier Formulary – Select Formulary – Ultra Select.

Vision

Marketplace Members of age 18 and under are eligible to receive an eye exam and corrective eyewear.

Please contact Envolve Vision at 1.844.293.1752.

Behavioral Health

HOW DO I GET HELP IF I HAVE BEHAVIORAL (MENTAL) HEALTH, ALCOHOL OR DRUG PROBLEMS?

If you or your dependent have a problem with drugs, alcohol or mental health, call Community Health Choice toll-free at 1.855.539.5881, 24 hours a day, seven days a week. Information is available in English and Spanish, and an interpreter is also available. In case of an emergency, call 9-1-1 or go to the nearest hospital.

DO I NEED A REFERRAL FOR THIS?

You do not need to see your Primary Care Provider (PCP) first or get a referral from your PCP. Some mental health or substance abuse problems may also need urgent care. For help with these problems or for more information, please call Community Health Choice.

Community follows the Mental Health Parity Addiction Equity Act (MHPAEA). We review to make sure that requirements for authorization and treatment of mental health benefits are equal to medical benefits.

Exhaustion of Benefits

Some benefits have limits. Once those limits are met, this is known as exhaustion of benefits, and you are responsible for the total cost of care.

Here are some consumer tools to assist you when you are responsible for the total cost of care and making healthcare decisions:

www.healthcarebluebook.com

www.webmd.com



VALUE-ADDED **PROGRAM**

Telehealth Services

Community Health Choice offers services through a telehealth vendor to all of its Marketplace Members.

Through a telehealth vendor, Community gives you 24/7/365 access to quality medical care via video and telephone consultations. The doctors available through our vendor are board-certified doctors licensed in the state of Texas. With these services, you have access to convenient, quality care at no cost to you. Call toll-free at 1.800.835.2362.

Through the telehealth vendor, services are provided for the treatment of many routine conditions, including cold and flu symptoms, respiratory infections, sinus problems, bronchitis, allergies, urinary tract infections, skin problems, and more.

WHEN SHOULD YOU USE TELEHEALTH SERVICES:

1. If you are considering the ER or an Urgent Care Center for non-emergency issues after hours.
2. If you are sick while on vacation, a business trip or away from home.
3. For non-narcotic, short-term prescriptions or refills when medically appropriate.
4. If your PCP offers Telehealth services.

COVERAGE FOR SERVICE PROVIDED OUTSIDE TEXAS

A covered health care service or procedure delivered as a telemedicine medical service, telehealth service, or teledentistry dental service will not be excluded from coverage solely because the originating site or distant site is located outside Texas. The service or procedure will be covered on the same basis and to the same extent as if the originating site or distant site were located in Texas.

Care Management Program

Our Care Management team focuses on coordinating healthcare interventions for Members who qualify. We concentrate on your needs by contacting you if we see that you may not be taking full advantage of available resources, such as medications and Providers. Our goal is to improve your awareness of ways to optimize your quality of life so that you are well every day. We identify pregnant Members who may be at risk for delivering their baby too early. When babies are delivered early, we help evaluate and coordinate any needs for the newborn once at home. Our Care Management team also follows certain Members who suffer from asthma or diabetes and helps them gain knowledge to self-manage their condition. We also help Members who may have trouble coordinating their own care. Call our Care Management department at 832.CHC.CARE (832.242.2273) or toll-free at 1.844.297.4450 to join.

Take charge of your health! Take our Health Risk Assessment online at www.CommunityHealthChoice.org to see if you have any potential health issues. We will review your results and contact you if we see any potential issues. Please remember to share your results with your doctor.

EMERGENCY, AFTER-HOURS CARE, NON-NETWORK PROVIDERS, AND OUT-OF-AREA SERVICES

What is an emergency or emergency care? How soon can I expect to be seen?

An emergency medical condition means your symptoms are severe and sudden and could place your health or life in jeopardy if you do not get help right away. For pregnant women, this includes sickness or injury of such nature that failure to get immediate medical care could result in serious jeopardy to the health of the fetus.

If you need emergency care:

1. Call 9-1-1 or go to the nearest network hospital emergency room; or
2. Find the nearest hospital emergency room if your condition does not allow you to go to a network hospital.
3. Call your doctor or PCP as soon as possible.

You, or someone on your behalf, must call us within 48 hours after you are admitted to a non-network hospital for emergency care. If your condition does not allow you to call us within 48 hours after you have been admitted, please contact us as soon as your condition allows. We may transfer you to a network hospital in our service area when your condition is stable. You must see a network Provider for any follow-up care.

What is urgent care? How soon can I expect to be seen?

Urgent care means health services or mental health services provided other than an emergency. Urgent care services are typically provided in a setting such as a physician or Provider's office or urgent care center as a result of acute injury or illness that is severe or painful enough that it would lead a person to believe that his or her condition, illness or injury is of such nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

An urgent problem is when you are sick or hurt and need treatment right away to keep you from getting worse. If your problem is urgent (but not an emergency), go to your PCP. You should expect to be seen for an urgent problem, including urgent specialty care, within 24 hours. Follow these steps for seeking after hours or urgent care services:

1. Contact your PCP, his/her back up or the on-call answering service.
2. If your PCP is not available, go to an urgent care center that is a network Provider. Search our online directory of network Providers at www.CommunityHealthChoice. org. Please check the online directory before you obtain services to ensure that the Provider is still in our network. If you do not have access to our online directory, contact Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.
3. You must receive any follow-up services from your PCP or 0a network Provider.
4. You must pay any deductible and/or copayment required for urgent care.

How do I get medical care after my Primary Care Provider's office is closed?

- Contact your PCP, his/her back up or the on-call answering service.
- Call our Medical Advice Line toll-free at 1.833.955.1528. Our nurses can help you get the right health care for your health concern. In an emergency, call 9-1-1 or go to the nearest emergency room.
- Call Teladoc Telehealth services if you are eligible. Community Health Choice offers telehealth services to all of its Marketplace Members. Call toll-free at 1.800.835.2362. Telehealth services give you 24/7/365 access to quality medical care via telephone at no cost to you. These doctors are board-certified physicians who are licensed in the state of Texas and have an average of 15 years of practice experience in adult and/or pediatric medicine. Read more about Telehealth services in the Value-Added Services Section of this handbook.

What is routine medical care? How soon can I expect to be seen?

Routine medical care is when you visit your Primary Care Physician in pursuit of good health. It includes preventive care, screenings, medical checkups, immunizations, treatment for illnesses, and follow-up care. You should expect to be seen within two weeks after you call them.

Using a Non-Network Provider

Community provides use of non-network Providers for if covered services are not available through our network Providers.

Except for emergencies, non-network Providers require prior authorization by Community. If we deny a prior authorization request for a referral to a non-network Provider, we will provide a review of the request by a Texas Licensed Physician of the same or similar type of specialty as the non-network Provider to whom the referral is requested.

Not all Physicians or Providers who provide services at network hospitals are network Providers. If services are provided by non- network Providers including, but not limited to, pathologists, anesthesiologists, radiologists, and emergency room physicians at a network hospital, we will pay for those services at the usual and customary rate or an agreed rate. We will also pay for non-network diagnostic imaging and laboratory services provided in connection with services provided by a network provider at the usual and customary rate or an agreed rate.

Texas law requires if services are not available from our network Providers as described above that you are only responsible for any applicable copayment or other out-of-pocket amounts that you would have paid if our network included network Providers from whom you could obtain services. If you receive a bill from the non-network Provider, please contact us at 1.855.315.5386.

It is your responsibility to verify if the Provider is in our network before you receive any non-emergency service. If the Provider is not in our network, you will be responsible for all costs incurred, unless we have authorized the services provided.

A health maintenance organization like Community provides no benefits for services you receive from non-network Providers, with specific exceptions as described above and in our Evidence of Coverage.

You have a right to an adequate network of Providers. If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

If we approve a referral for non-network Provider services because no network Provider is available or if you have received emergency care services provided by a non-network Provider, we must, in most cases, resolve the non-network Provider's bill so that you only have to pay any applicable network copayment, coinsurance or deductible amounts.

You may obtain a current directory of network Providers at www.CommunityHealthChoice.org. Our online directory is updated every week. If you do not have access to our online directory, contact Community Member Services at 713.295.6704, or toll-free at 1.855.315.5386 or email

MemberServices@CommunityHealthChoice.org. If you relied on materially inaccurate directory information, you may be entitled to have a claim by a non-network Provider paid as if it were from a network Provider if you present a copy of the inaccurate directory information to us dated not more than thirty (30) days before you received the service.

What if I get sick when I am outside of the service area?

The only services covered if you are outside of the service area are emergency services or services authorized by Community.

If you need emergency services while outside of our service area, go to the nearest hospital. We cover care for true emergencies when outside of our service area. You do not need to call your PCP before receiving emergency care. You must receive any follow-up services to an emergency room visit from your PCP or a Network Provider.

To ensure your follow-up care is covered following emergency services you will need to return to our designated service area.

What do I do when I receive a bill for services received outside of the service area?

If you receive a service outside of our service area that will not be billed to Community by the physician or provider, you must send us a letter with your name, the service received, and your Member ID number.

Mail the letter to the address on your Member ID card. Community must receive this letter informing us of the claim no later than ninety (90) days after the date of service.

If you received emergency care outside the United States, please include the following information with your claim.

1. Your name, the services received, and Member number
2. Community Medical Claim Form found on our website
3. Authorization for the release of medical information including the names of all providers that rendered services to you.
4. An itemized bill including procedures and diagnosis
5. If possible, a letter of medical necessity and procedure notes from the treating provider
6. Proof of payment for the medical care
7. Information about other insurance coverage

Except for emergency services and specific exceptions described above and in our Evidence of Coverage, your plan does not cover any benefits outside of your plan's service delivery area. If you received care outside of the United States, in addition to the information above, please also submit:

1. Proof of travel outside the United States such as airline tickets or passport stamps
2. An explanation of care outside the United States

Community will acknowledge that we received the claim within fifteen (15) days, and we will research this information. We may need to contact you for more information.

What do I have to do if I move?

At least fourteen (14) days prior to your move, if you are an off-exchange Member, notify us of your new residence and phone number. If you are an on-exchange Member, please contact the Marketplace to update your application. When we receive your information, we will inform you of any changes to your plan on topics such as new networks, benefits, and premiums. If you move outside of our service area, we will terminate your coverage.

Please read the Renewability and Termination section in the Evidence of Coverage for more information.

FINANCIAL **RESPONSIBILITIES**

Premium Payment

Your monthly premium is due by the last day of the month before coverage will begin.

FOR EXAMPLE:

June Coverage	Payment due May 31
June Coverage	Delinquency begins June 1

If your premium is not received by the due date, your coverage may be terminated. The best way to avoid delays in care and obtaining prescription is to pay your premiums on time. All payments received after the fifth of the month will be shown on the next month's invoice. Payments can be made in one of four ways:

- Credit card payment by telephone
- Electronic payment through the Community Health Choice My Member Account
- Paper check or money order mailed directly to Community Health Choice

PREMIERE AND SELECT PLANS:
PAPER CHECKS OR MONEY ORDERS SHOULD BE MADE PAYABLE AND MAILED TO:

COMMUNITY HEALTH CHOICE
P.O. Box 844124
Dallas, TX 75284-4124

ULTRA SELECT PLANS:
PAPER CHECKS OR MONEY ORDERS SHOULD BE MADE PAYABLE AND MAILED TO:

COMMUNITY HEALTH CHOICE
P.O. Box 411925
Boston, MA 02241-1925

What happens if I do not pay my premium on time?

If you qualify for Advanced Premium Tax Credits (APTC), you will have a ninety (90) day grace period. If payment (and any back-due payment) is not received within those ninety (90) days, your coverage will be terminated. You will be responsible for services not paid to Providers by Community. Providers will seek payment directly from you.

If you do not qualify for APTC, you will have a thirty-one (31) day grace period. If payment is not received within those thirty-one (31) days, your coverage will be terminated. Providers will seek payment directly from you.

Deductibles/Copayments

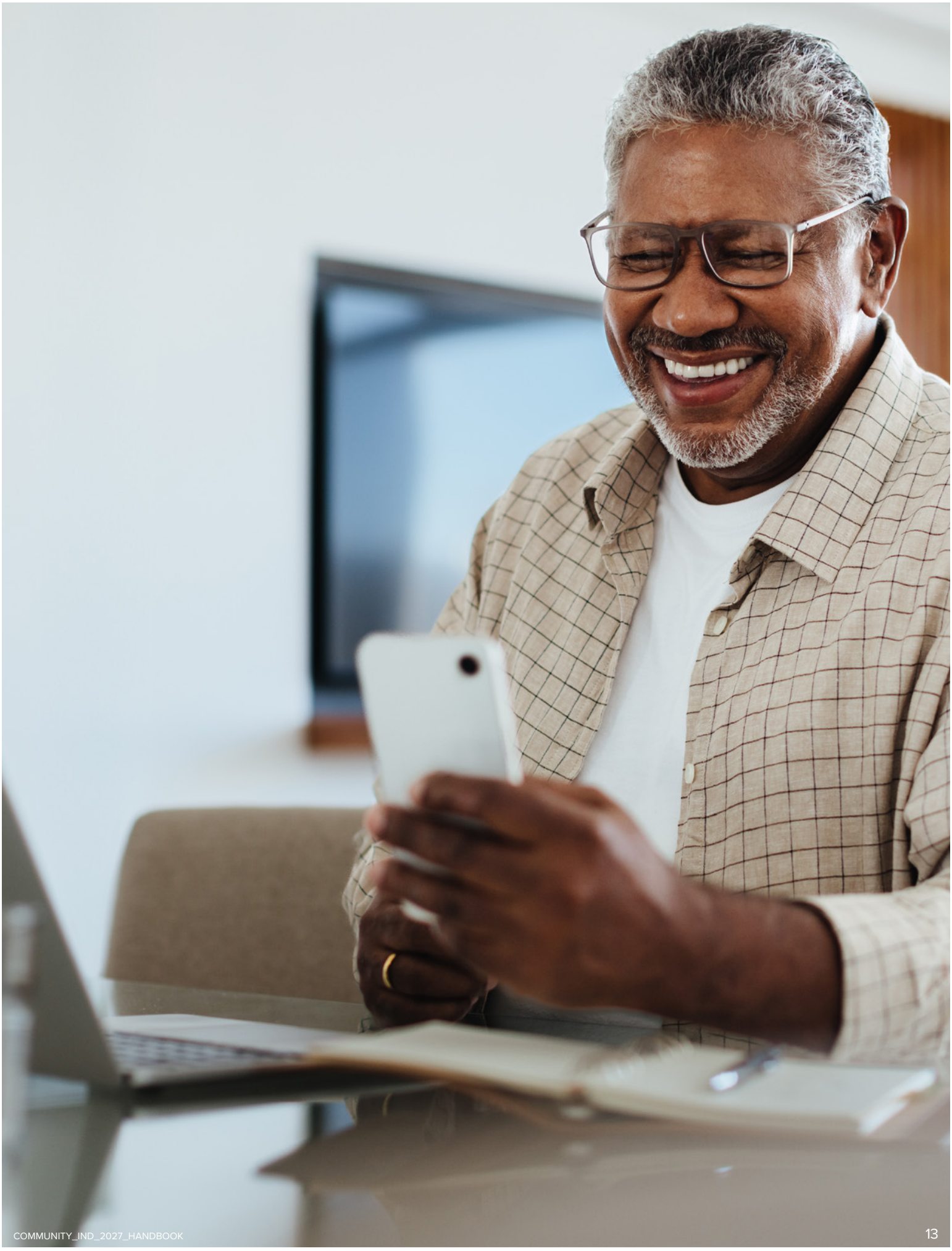
In addition to your monthly premium payment, you are responsible for all applicable deductibles and copayments for covered services. Deductibles only apply to consumer choice health plans. Please read the definition of these terms under Health Coverage Definitions. You may also be responsible for all non-covered services and, in some cases, out-of-area expenses.

This information is included in the Summary of Benefits and the Evidence of Coverage, both of which are available online at www.CommunityHealthChoice.org. We can also mail you a copy. Contact Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org. You can also log in to your My Member Account. See your member guide for additional instructions.

Note: Deductibles only apply to Consumer Choice health benefit plans.

Use of Network Providers

In most instances, there are network Providers available to provide services. Network Providers have agreed to accept discounted or negotiated fees. You are responsible for paying the network Provider for any applicable deductible and/or copayment for services received. We offer different managed care plans, and a provider who participates in one plan may not necessarily be a network Provider for other plans offered by Community. When receiving services, you must make sure the provider participates as a network Provider in your plan to avoid additional out-of-pocket expenses.



LIMITATIONS

Community does not provide coverage for all healthcare expenses. Your plan does contains limitations and exclusions. Following is a summary of services that are not covered.

Additional exclusions or limitations may apply. Please refer to the Evidence of Coverage for more details to determine which healthcare services are covered and to what extent.

These limitations and exclusions apply, even if a physician or Provider has performed or prescribed a medically appropriate service. This does not prevent your Provider from providing or performing the service; however, it will not be a covered service that we pay for.

General Exclusions or Limitations:

- Services provided by a non-network Provider, except when authorized by Community or for emergency services
- Services incurred before or after coverage begins or ends
- Services that are not medically necessary
- Charges for prophylactic services
- Services that are experimental or investigational
- Services relating to an illness or injury incurred as a result of the covered person being intoxicated or under the influence of illegal narcotics or a controlled substance
- Services relating to illness or injury to the body incurred as a result of intentionally self-inflicted bodily harm, war or an act of war, taking part in a riot, engaging in an illegal occupation, any act of armed conflict or any conflict involving armed forces or any authority
- Cosmetic services or any complication resulting from cosmetic services except as described in the Evidence of Coverage
- Custodial care and maintenance care
- Ambulance services for routine transportation to, from or between medical facilities and/or a Physician or Provider's practitioner's office
- Infertility treatment
- Reversal Sterilization
- Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses unless specified in this contract
- Dental services
- Any treatment for obesity or complications related to such treatment.
- Foot-care services in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy or chronic arterial or venous insufficiency
- Hair prosthesis, hair transplants or hair implants
- Hearing care, except as expressly provided in the Evidence of Coverage
- Over-the-counter medical items or supplies
- Immunizations including those required for foreign travel except as provided in the Evidence of Coverage
- Treatment for any jaw joint problem
- Genetic testing or services except as provided in the Evidence of Coverage
- Services received in an emergency room not affiliated with a hospital, unless emergency care
- Any expense incurred for services received outside of the United States, except for emergency care services
- Charges for alternative medicine
- Private-duty nursing, except inpatient private-duty nursing when medically necessary).
- Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement

Prescription Drug Exclusions or Limitations

- Drugs that are not included on the Drug Formulary
- Dietary supplements, except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or certain other inherited metabolic diseases and amino-acid-based elemental formulas as provided in the Evidence of Coverage, and except as required for coverage of autism spectrum disorder services under applicable law.
- Nutritional products, except as required for covered autism spectrum disorder services under applicable
- Any drug prescribed for intended use other than for indications approved by the FDA or off-label indications recognized through peer-reviewed medical literature
- Any drug, medicine or medication that is either labeled "Caution: limited by federal law to investigational use" or experimental or investigational
- Allergen extracts
- Drug delivery implants
- Athletic performance enhancement drugs
- The administration or injection of any drugs
- Therapeutic devices or appliances, except as expressly provided in the Evidence of Coverage
- Anorectic or any drug used for the purpose of weight control
- Abortifacients (drugs used to induce abortions)
- Any drug used for cosmetic purposes
- Infertility treatment medications
- Any drug prescribed for impotence and/or sexual dysfunction
- Drugs administered by a clinician in a healthcare facility or clinic setting are not covered under the outpatient prescription drug benefit. These drugs may be covered under the medical benefit, subject to the terms of the Evidence of Coverage and applicable law.

Further, not all prescription drugs are covered under this plan, and some prescriptions require prior authorization. Please review the preferred drug list first. Contact your Provider, if necessary, to obtain prior authorization or a referral for a covered prescription drug.

In some cases, you may have to try one prescription before receiving authorization to take another prescription drug. This is called step-therapy. Your Provider may request you skip one of these drugs for medical reasons. If so, your Provider must contact Community to request a medical exception.

If certain conditions are met, step therapy is not required for prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Community Health Choice requires Members to use generic medications when available. In order to approve the use of a brand drug when a generic is available, the Provider must submit a prior authorization request. If the brand drug is authorized, the Member will pay the applicable tier copay.

If use of the brand drug is not approved but the Member wants the brand drug dispensed, the Member will pay the applicable tier copay of the brand drug plus the cost difference between the brand and generic drug. This amount will not apply to the Member's deductible or maximum out of pocket. Certain high-cost generic drugs may be included on a higher tier and thus have a higher copay.



PRIOR AUTHORIZATION

Prior Authorization

Prior authorization means Community reviews proposed services and prescription drugs to determine if they are medically necessary before they are provided. We require prior authorization for certain services and prescription drugs, unless your Physician or Provider has a prior authorization exemption for the particular services and/or prescription drugs.

Prior authorization is not a guarantee of payment; final reimbursement depends entirely on your active eligibility status and specific plan coverage on the date of service.

Services and prescription drugs that do or do not require prior authorization are subject to change. We have a list of services that require prior authorization and a prescription drug formulary that tells you when prior authorization is required for prescription drugs. To obtain a list, contact our Member Services Department at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org, or go to: Formulary – Premier Formulary – Select Formulary – Ultra Select.

Your physician or Provider must contact us by telephone, electronically or in writing to request the appropriate authorization. The telephone number to call to request authorization is on your Member Identification Card. No benefits are payable for services or prescription drugs that are not covered services.

We will issue a determination on a request for prior authorization no later than three (3) calendar days for standard sevice request after receiving the request. If the prior authorization is urgent, we will issue a determination within 1 working day of receipt. If the prior authorization involves a concurrent hospital care, we will issue a determination within twenty-four (24) hours of receiving the request.

If the prior authorization involves post-stabilization treatment or a life-threatening condition, we will issue a determination within the timeframe appropriate for the circumstances relating to the delivery of the services and conditions of the enrollee, but in no case to exceed one hour from receipt of the request.

Your physician or provider may request a renewal of an existing prior authorization request sixty (60) days before the date it expires. If we receive a request before the existing prior authorization expires, we will, if practicable, review the request and issue a determination before the existing prior authorization expires.

Please read all of the information about prior authorizations in the Evidence of Coverage. It is available online at Know the Details 2027 – Community Health Choice. We can mail you a copy upon request. Contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

CONTINUITY OF **CARE**

If you have special circumstances, you may be eligible for continuation of services from a terminated Provider through continuity of care. A terminated Provider is a Network Provider whose contract is terminated or not renewed.

All terms and provisions of this contract are applicable to covered services provided during the period of continued care by the terminated Provider.

CONTINUITY OF CARE IS NOT AVAILABLE:

1 If the Provider was terminated due to reason of medical competence or professional behavior;

2 After the 90th day after the effective date of the Provider's termination; or

3 After the expiration of the nine-month period after the effective date of the Provider's termination if the Member was diagnosed as having a terminal illness at the time of the termination.

If you are past the 24th week of your pregnancy at the time of the Provider's termination, continuity of care extends through delivery of your child and applies to the immediate postpartum care and follow-up checkup within the six-week period after delivery.

MEMBER RIGHTS AND **RESPONSIBILITIES**

Effective healthcare delivery requires a partnership between patients and their healthcare Providers. In order to facilitate an effective relationship between Providers and Members, it is important for Community Members to understand their rights and responsibilities. Therefore, Community has adopted the following Members' Rights and Responsibilities statement:

1 A right to receive information about the organization, its services, its practitioners and Providers, and Member rights and responsibilities

2 A right to be treated with respect and recognition of your dignity and your right to privacy

3 A right to participate with practitioners in making decisions about your health care

4 A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage

5 A right to voice complaints or appeals about Community or the care it provides

6 A right to make recommendations regarding Community's Member rights and responsibilities policy

7 A responsibility to supply information (to the extent possible) that Community and its practitioners and Providers need in order to provide care

8 A responsibility to follow plans and instructions for care that you have agreed to with our practitioners

9 A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

Community is committed to providing high-quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are overseen by the Member's signed benefit contract and not by this Member Rights and Responsibilities statement.

YOUR RIGHTS WITH A HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

NOTICE FROM THE TEXAS DEPARTMENT OF INSURANCE

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called “contracted providers” (also known as “in-network providers”). Contracted providers make up a plan’s network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn’t pick the doctor, and for ambulance services.

Your plan’s network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn’t have to travel too far or wait too long to get care. This is called “network adequacy.” If you can’t find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don’t think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800.252.3439.

List of doctors

You can get a directory of health care providers that are in your plan’s network.

You can get the directory online at www.CommunityHealthChoice.org or by calling 713.295.6704 or toll-free at 1.855.315.5386.

If you used your health plan’s directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn’t pick the doctor, you won’t have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

As of January 1, 2022, the No Surprises Act prohibits surprise billing for Consumers with:

1. Out-of-network emergency services, including air ambulance (but not ground ambulance) services; and
2. In-network non-emergency services provided under certain circumstances.

If you get a bill for more than you’re expecting, contact your health plan. Learn more about how you’re protected from surprise medical bills at tdi.texas.gov.

COMPLAINTS AND APPEALS OF ADVERSE DETERMINATIONS

Complaint

You, your Provider, or your representative can file a complaint on your behalf. If you have a complaint, please call us at 713.295.6704 or toll-free at 1.855.315.5386. A Community Health Choice Member Services Advocate can help you file a complaint. Most of the time, we can help you right away, or at the most, within a few days. If you need language assistance to file your complaint, please contact Member Services toll-free at 1.855.315.5386.

If you complain orally, we will send you a one-page Complaint Form. The Complaint Form must be returned to us for prompt resolution. You can also write a letter. Send your complaint to the address below:

Community Health Choice Service Improvement Team
4888 Loop Central Drive, Suite 600
Houston, TX 77081

Within five (5) business days from the date of receipt of your complaint, We will send you a letter telling you that we received your complaint. This letter will explain the complaint process. Community documents the substance of your complaint and investigates each complaint received. We will send you a resolution letter within thirty (30) calendar days from the date of receipt of your written complaint or receipt of the one-page Complaint Form.

If your complaint is concerning an emergency or denial of continued stay for hospitalization, it will be resolved no later than one (1) business day after we receive the complaint. The investigation and resolution will be concluded in accordance with the medical or dental immediacy of the case. Community will provide a review by a physician who:

- Has not previously reviewed the case; and
- Is of the same or a similar specialty as the physician or Provider who would typically manage the medical condition, procedure or treatment under consideration

The physician or Provider reviewing the appeal may interview the patient or the patient's representative and will decide the appeal. The initial notice will be given orally with a written notice within three (3) days after the decision.

If the complaint is not resolved to your satisfaction, you have the right to appeal to a Complaint Appeal Panel (CAP). You may appear in person before a CAP where you normally receive healthcare services, unless another site is agreed to by you or you address a written appeal to the CAP. The CAP will have equal numbers of:

- Our staff
- Providers
- Members

Members of the CAP cannot have been a part of the complaint in any way. Providers will have expertise in the appropriate area of care. Health Insurance Marketplace Members on the CAP cannot be employees of Community.

You will receive an acknowledgement letter within five (5) business days after we receive your written request for a CAP. No later than five (5) business days before the CAP is to meet, unless you agree otherwise, we will give you or your representative:

- Any documentation to be presented to the CAP by Community;
- The specialization of Provider or physician consulted during the investigation; and
- The name and affiliation of each Community staff person on the CAP.

A Member or his/her representative, if the Member is a minor or is disabled, has the right to:

- Meet in person with the CAP;
- Have other expert testimony presented to the CAP; and
- Ask for any person involved in making the decision that caused the complaint to be at the meeting and to q uestion them.

The CAP will only serve to advise Community. Community will consider the findings of the CAP and render our final decision. The appeal process will be finished within thirty (30) calendar days from the date we received your written request for an appeal. Community will send you a letter with the final decision on the appeal.

If you are not satisfied with the answer to your complaint, you may also send your complaint to the Texas Department of Insurance by calling toll-free at 1.800.252.3439. If you would like to make your request in writing, send it to:

Texas Department of Insurance Consumer Protection
P.O. Box 12030
Austin, TX 78711-2030
E-mail: ConsumerProtection@tdi.texas.gov

Community is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against Community or appealed a decision of Community. Community is prohibited from retaliating against a physician or Provider because the physician or Provider has, on behalf of an enrollee, reasonably filed a complaint against Community or appealed a decision of Community.

APPEALS

Appeals

An adverse determination is a determination made by Community that the healthcare services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. You have the right to appeal an adverse determination or non-coverage decision. You, your Provider or someone else you choose as your representative may also appeal. You have one hundred eighty (180) days from the date of the adverse determination to file your appeal. You may request your appeal verbally or in writing. Please send your appeal to:

Community Health Choice
Attention: Medical Affairs- Appeals
4888 Loop Central Drive, Suite 600
Houston, TX 77081
713.295.6704 or 1.855.315.5386
Fax to: 713.295.7033/Attn: Appeals Coordinator

If you need language assistance to file your appeal, please contact Member Services Toll-free at 1.855.315.5386.

You may mail your Behavioral Health appeal to the address below:

Community Health Choice
Attn: Behavioral Health Appeals
P.O. Box 301411
Houston, TX 77230
Fax: 713.576.0934 (Standard Appeal Requests)
Fax: 713.576.0935 (Expedited Appeal Requests)

During the Appeal Process

If you are hospitalized, We will notify you within one working day by telephone or electronic transmission followed by written notice within three (3) working days. If you are not hospitalized, written notification will be provided within three (3) working days.

Community may need additional information to help us with your appeal. The letter will include a list of documents that you, your representative or Provider should send to Community for the appeal. You have the right to give us information that supports your appeal. You may review any information we use to make our decision.

Community will have someone review the appeal to make sure we have all the required information. Community will also have a doctor review your appeal. This doctor will be trained in treating your type of illness and will not have been part of the original decision.

Answering your Standard Appeal

Community will answer your appeal within thirty (30) calendar days after the date received. The written response will include:

- Reasons for the appeal decision
- Clinical basis for the decision
- Types of doctors that reviewed the appeal, including the specialty type
- Your right to a review by an Independent Review Organization (IRO) and how to request an IRO
- Your right to request a copy of the guidelines used to make our decision (unless it is determined that the healthcare service provided or proposed is not covered for reasons other than an Adverse Determination. For example, it is not a covered benefit or it is expressly excluded).

You have a right to reasonable access and copies of all documentation upon request.

Your Provider has the right to ask for a specialty review within ten (10) days of our decision.

Expedited Appeal Process

You have the right to ask for an expedited appeal. This type of appeal is about emergencies, continued hospitalizations, life-threatening conditions or circumstances involving the provision of prescription drugs or intravenous infusions for which you are receiving benefits. You can request an expedited appeal, either orally or in writing.

Expedited appeal requests will be decided based on the medical or dental immediacy of your condition, procedure or treatment, but in no event later than one (1) business day from the date all information necessary to complete the appeal is received or seventy-two (72) hours, whichever is less. A determination may be provided by telephone or electronic transmission, but will be followed with a letter within three (3) working days of the initial telephone or electronic notification.

You have a right to reasonable access and copies of all documentation upon request.

Independent External Review – Appeals

Community utilizes Maximus to perform external review. The IRO will give You and Us written notice of the final external review decision as soon as possible.

For a Standard External Review, the IRO reviewer Must reach a decision within 45 days. In cases involving life-threatening conditions, the IRO must reach a decision within 72 hours.

If We do not approve a Drug Formulary exception request as described in Section 3, “Your Contract Benefits Management, “Section n “Prescription Drugs, “You may request an external review. The IRO will issue a response to you or your legal representative no later than 72 hours from receipt of your request. For an expedited appeal for prescription drugs, the IRO will issue a response to you or your legal representative no later than 24 hours from receipt.

Independent Review Organization Process

HOW DO I REQUEST AN IRO REVIEW?

You can request an Independent Review Organization by contacting Maximus at 1.888.866.6205. All External Review requests must be sent to MAXIMUS Federal Services. Send your request for External Review directly to MAXIMUS at: MAXIMUS Federal Services State Appeals East 3750 Monroe Avenue, Suite 708 Pittsford, NY 14534 Fax number: 1-888-866-6190. You can send the request through the online portal at https://externalappeal.cms.gov/ under the 'Request a Review Online" option. If you have any questions or concerns during this process, you can call MAXIMUS toll-free at 1-888-866-6205. You can submit written comments to the MAXIMUS examiner at the mailing address above. You can contact Member Services at Community Health Choice if you need any additional information at 713-295-6704, toll-free at 1.855.315.5386.

WHAT ARE THE TIME FRAMES FOR THIS PROCESS?

For a Standard External Review, the IRO reviewer must reach a decision within 45 days. In cases involving life-threatening conditions, the IRO must reach a decision within 72 hours.

Answering your Standard Pharmacy Drug Appeal

Community will answer your appeal of a formulary exception within seventy-two (72) hours following receipt of the request and all the necessary information to complete the appeal.

THE WRITTEN RESPONSE WILL INCLUDE:

- Reasons for the appeal decision
- Clinical basis for the decision
- Types of doctors that reviewed the appeal, including the specialty type
- Your right to a review by Texas Department of Insurance Independent Review Organization (IRO) and how to request an IRO (unless it is determined that the healthcare service provided or proposed is not covered for reasons other than an Adverse Determination; for example it is not a covered benefit or it is expressly excluded)
- Your right to request a copy of the guidelines used to make our decision

You have a right to reasonable access and copies of all documentation upon request.
Your Provider has the right to ask for a specialty review within ten (10) days of our decision.

Expedited Pharmacy Appeal Process

You have the right to ask for an expedited appeal. This type of appeal is about emergencies, continued hospitalizations and life-threatening conditions. You can request an expedited appeal either orally or in writing. Expedited appeals for prescription drugs will be decided within one (1) business day. You have a right to reasonable access and copies of all documentation upon request.

Independent External Review – Pharmacy Appeals

If Community denies your request for services after you have exhausted the Community Health Choice internal appeal process, you have the right to a review of an appeal by an IRO (unless it is determined, that the healthcare service provided or proposed is not covered for reasons other than an Adverse Determination; for example, it is not a covered benefit, or it is expressly excluded). An independent review is when someone not employed by Community reviews your request for services.

Community will send you information on how to request an IRO and the Request Form with the appeal response letter.

A determination on the external exception request will be rendered, and the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) will receive notification of the coverage determination no later than seventy-two (72) hours following receipt of the request and all the necessary information to complete the appeal.

Retrospective Adverse Determinations

Retrospective reviews will be made within a reasonable period but not to exceed thirty (30) days after the request is received. The determination will be sent in writing to the Provider, enrollee or a person acting on behalf of the enrollee.

Complaints Regarding Adverse Determinations

You may also file a complaint with the Texas Department of Insurance if you are not satisfied with Community Health Choice Appeal process:

Texas Department of Insurance Consumer Protection Section
(MC 111-1A)
P.O. Box 12030 Austin, TX 78711-2030
E-mail: ConsumerProtection@tdi.texas.gov
1.800.252.3439

CHOOSING YOUR PROVIDERS

Finding a Network Provider

Search our online directory of Network Providers at www.CommunityHealthChoice.org. Our online directory is updated in real time. Please check the online directory before you obtain services to ensure that the Provider is still in our Network. When searching, be sure to select the correct network for the plan in which you are enrolled. If you do not have access to our online directory, contact Community Member Services at 713.295.6704, Toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

Our online directory provides an alphabetical listing of all the physicians and Providers, including specialists. Our online directory also provides a listing for behavioral health and substance abuse treatment Providers. Search our online directory at www.CommunityHealthChoice.org.

Using a Network Provider

In most instances, there are participating Providers available to provide Medically Necessary services. Participating Providers have agreed to accept discounted or negotiated fees. You are responsible for paying the participating Provider for any applicable deductible and/or copayment for services received. We offer different managed care plans, and a provider who participates in one plan may not be a Participating Provider for other plans offered by Community Health Choice.

Non-Network Providers have not signed an agreement with Community. You will be responsible for paying the difference between their full price and our approved amount.

Seeing a Specialist

Discuss all your medical needs with your PCP. If you and your PCP determine that you need to see a specialist, your PCP should refer you to a specialist in our Provider Network. We have a wide range of specialists in our Provider Network. Although we allow open access to specialists without a referral from a PCP or authorization from us, some specialists will require a referral from your PCP.

What is a referral? What services need a referral?

A referral is a consultation for evaluation and/or treatment of a patient requested by one doctor to another doctor.

All medical needs should be discussed with the PCP. Although we allow open access to specialty care physicians without a referral from a PCP or authorization from us, some specialty care physicians will require a referral from your PCP. If you and your PCP determine that there is a need to see a specialty care physician, the PCP can recommend one specific to your medical needs.

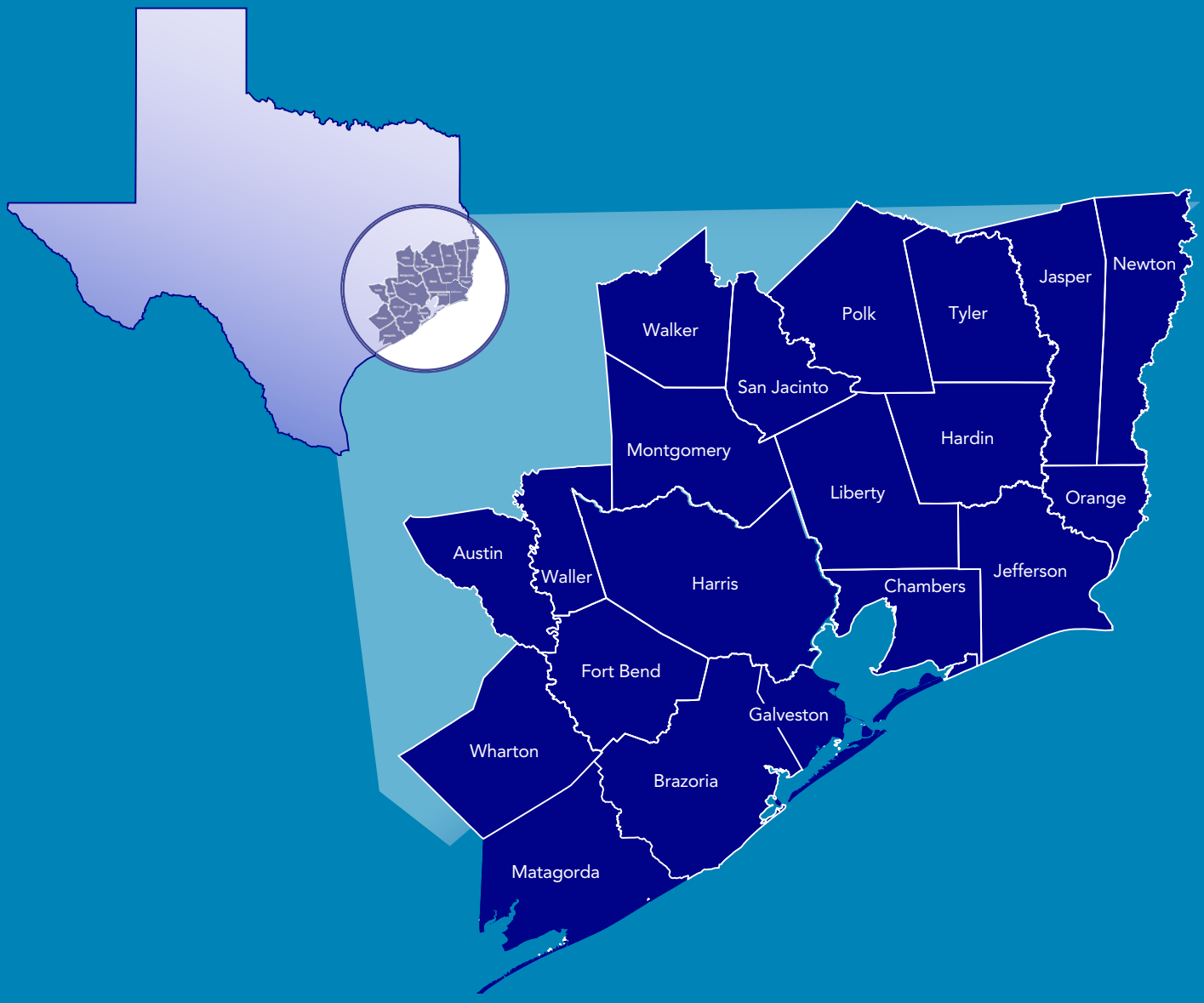
We do require prior authorization for certain services. Visit our Web site at Prior Authorization Information or call the Member Services' telephone number on your Member ID card for a list of services that require prior authorization.

What does "Medically Necessary" mean?

Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Physician or Provider would provide to his/her patient for the purpose of diagnosing, alleviating or treating an illness or bodily injury or its symptoms. The fact that a Physician or Provider may prescribe or direct a service does not make it medically necessary or covered under this illness. Such healthcare service, treatment or procedure must be:

1. In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use;
2. Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
3. Not primarily for the convenience of the patient or Physician or Provider;
4. Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
5. Performed in the most cost-effective setting required by the patient's condition;
6. Supported by the preponderance of nationally recognized, peer-reviewed medical literature, if any, published in the English language as of the date of service; and
7. Not experimental, investigational or for research purposes.

MARKETPLACE **SERVICE AREAS**



USING YOUR **BENEFITS**

Benefit Information

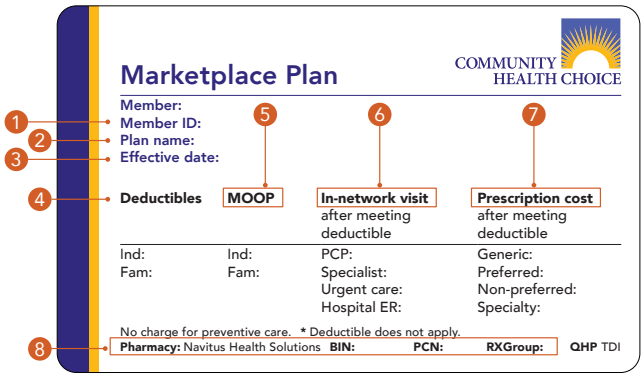
You may obtain all Member benefit information online at www.CommunityHealthChoice.org through your My Member Account page. You may also contact Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

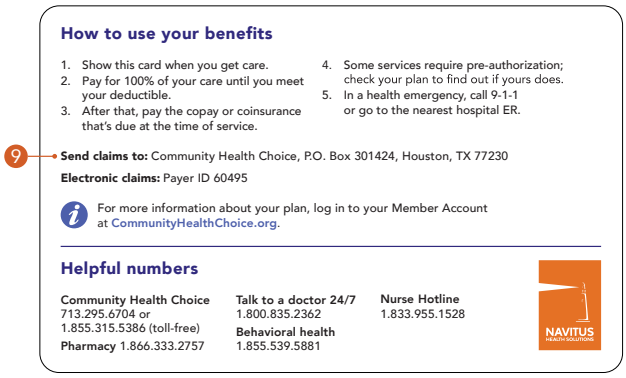
Creating a Member Account

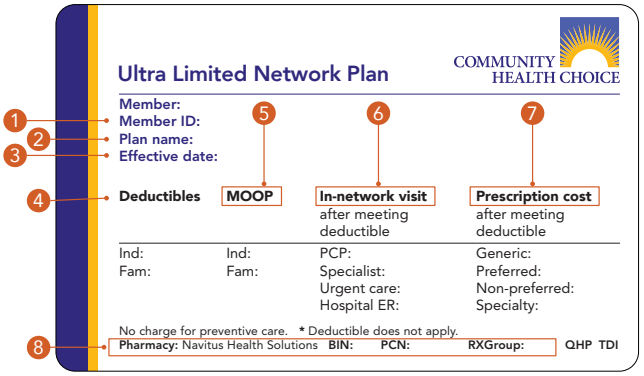
To create a Member account:

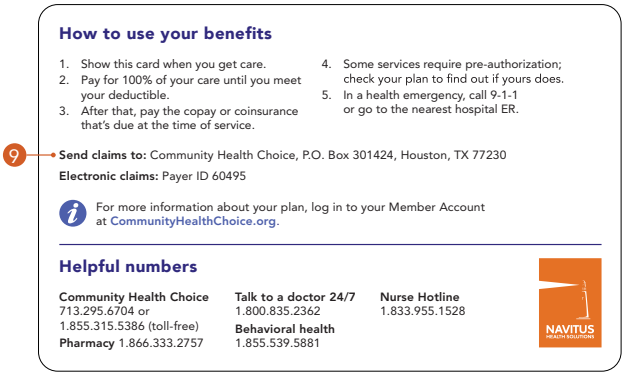
- Go to www.CommunityHealthChoice.org
- Click on the Member Login
- Select “Health Insurance Marketplace” as the product
- Click “Create an Online Account”
- Enter your Member Information

YOUR COMMUNITY CARE MEMBER **ID CARD**









1 **MEMBER ID**
Your unique identifier. Use this ID number for all claims and inquiries. This is also the number used to create your My Member Account.

2 **PLAN NAME**
This is the plan you selected.

3 **EFFECTIVE DATE**
Date coverage begins.

4 **DEDUCTIBLE**
The amount you must pay for healthcare expenses before insurance covers the costs.

5 **MOOP (MAXIMUM OUT-OF-POCKET)**
The limit on annual out-of-pocket expenses that you’ll pay for medical services that are covered by your insurance plan. After you reach the MOOP, you won’t pay any additional cost-sharing for medical services until the next plan year.

6 **COPAYMENT/COINSURANCE**
A specified dollar amount or amount expressed as a percentage you are obligated to pay toward covered expenses of certain benefits specified.

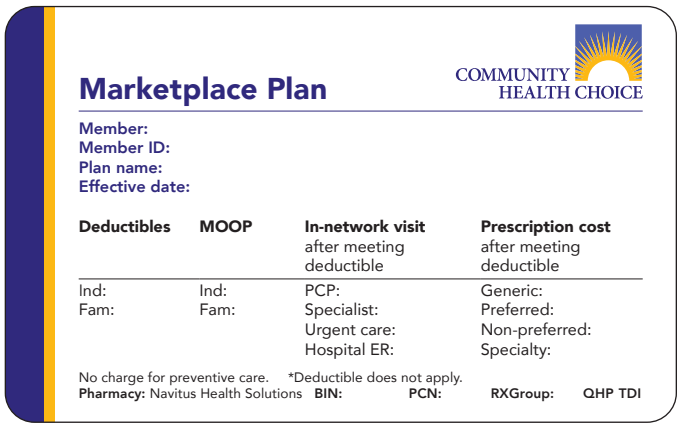
7 **PRESCRIPTION COST**
The amount you must pay for medication.

8 Your pharmacist will use this information to process your prescription.

9 Your Provider will use this information to process your claim.

Marketplace Member ID Card

Take your ID card with you whenever you get medical services.



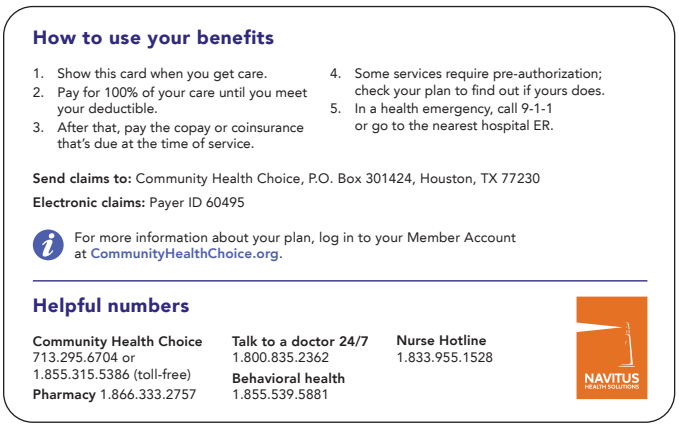
Marketplace Plan

COMMUNITY HEALTH CHOICE

Member:
Member ID:
Plan name:
Effective date:

Deductibles	MOOP	In-network visit after meeting deductible	Prescription cost after meeting deductible
Ind: Fam:	Ind: Fam:	PCP: Specialist: Urgent care: Hospital ER:	Generic: Preferred: Non-preferred: Specialty:

No charge for preventive care. *Deductible does not apply.
Pharmacy: Navitus Health Solutions **BIN:** **PCN:** **RXGroup:** **QHP TDI**



How to use your benefits

1. Show this card when you get care.
2. Pay for 100% of your care until you meet your deductible.
3. After that, pay the copay or coinsurance that's due at the time of service.
4. Some services require pre-authorization; check your plan to find out if yours does.
5. In a health emergency, call 9-1-1 or go to the nearest hospital ER.

Send claims to: Community Health Choice, P.O. Box 301424, Houston, TX 77230
Electronic claims: Payer ID 60495

For more information about your plan, log in to your Member Account at CommunityHealthChoice.org.

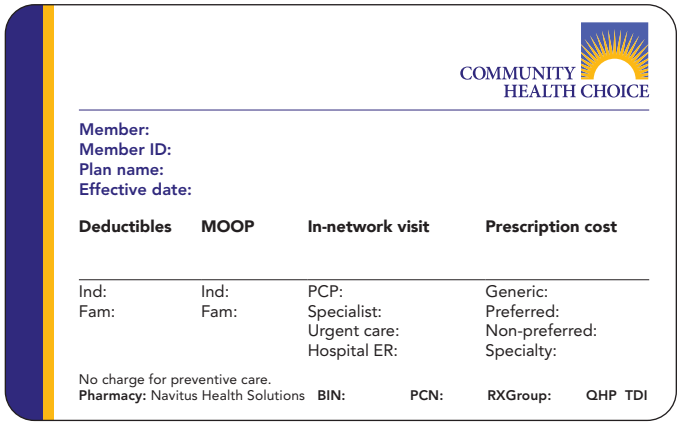
Helpful numbers

Community Health Choice
713.295.6704 or
1.855.315.5386 (toll-free)
Pharmacy 1.866.333.2757

Talk to a doctor 24/7
1.800.835.2362
Behavioral health
1.855.539.5881

Nurse Hotline
1.833.955.1528

NAVITUS HEALTH SOLUTIONS

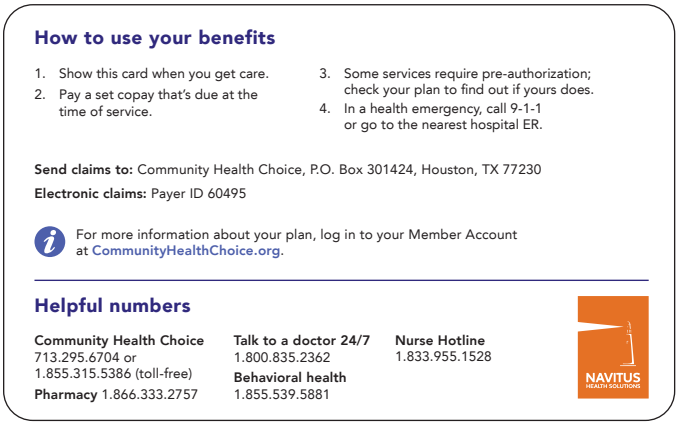


COMMUNITY HEALTH CHOICE

Member:
Member ID:
Plan name:
Effective date:

Deductibles	MOOP	In-network visit	Prescription cost
Ind: Fam:	Ind: Fam:	PCP: Specialist: Urgent care: Hospital ER:	Generic: Preferred: Non-preferred: Specialty:

No charge for preventive care.
Pharmacy: Navitus Health Solutions **BIN:** **PCN:** **RXGroup:** **QHP TDI**



How to use your benefits

1. Show this card when you get care.
2. Pay a set copay that's due at the time of service.
3. Some services require pre-authorization; check your plan to find out if yours does.
4. In a health emergency, call 9-1-1 or go to the nearest hospital ER.

Send claims to: Community Health Choice, P.O. Box 301424, Houston, TX 77230
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For more information about your plan, log in to your Member Account at CommunityHealthChoice.org.

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Behavioral health
1.855.539.5881

Nurse Hotline
1.833.955.1528

NAVITUS HEALTH SOLUTIONS

*This is a sample ID card. Your ID card may have slight differences based on the plan design and requirements.

Selecting Your Primary Care Provider

Once you have made your initial payment, you may select a Primary Care Provider (PCP) to give you medical care. You must select a PCP for yourself and for each covered dependent.

When you select a PCP, that PCP will be your medical home. As your medical home, your PCP needs to know everything about your past and present healthcare needs. Make sure your PCP has all your medical records. If you are a new patient, help your PCP get your medical records from your previous doctor. You may need to sign a form giving permission for your medical records to be sent to your new PCP.

We give you several choices to select for PCP services. The following physician and Provider types may serve as PCPs:

- Network physicians from any of the following practice areas: General Practice, Family Practice, Internal Medicine or Pediatrics.
- Advanced Practice Nurses (APNs) and Physician Assistants (PAs) when practicing under the supervision of a physician designated as a PCP Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and similar community clinics.
- Specialty Care Physicians who are willing to be a PCP for select Members with a chronic, disabling or life-threatening illness.
- ATTENTION FEMALE ENROLLEES: You have the right to select an OB/GYN to whom you have access without first obtaining a referral from your PCP. Community has opted not to limit your selection of an OB/GYN to only those listed in Community's network as an OB/GYN. You may elect to receive your OB/GYN services through your PCP, and you are not required to select an OB/GYN.

If you have a chronic, disabling or life-threatening illness, you may apply to our medical director to use a specialty care physician as your PCP. Call Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 to make this request. If your request is denied, you have the right to seek review of the denial through our Complaints process.

If you are an inpatient (for example, in a hospital), on admission to the inpatient facility, a physician other than your PCP may direct or oversee your care.

What if I receive a bill from a Network Provider?

You should not receive a bill from a Network Provider for a covered service. If you do, call Community Member Services for help at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org. You may be required to submit a copy of the itemized billing statement and a copy of your Member ID card. Please be sure to provide your doctor's office with your insurance information prior to calling Community Health Choice.

Changing your Primary Care Provider

You may change your PCP by calling Member Services at 713.295.6704 or toll-free at 1.855.315.5386. The effective date of the PCP change is on the first of the following month.

In the meantime, your current PCP will continue to coordinate your care. You must arrange to have your or your dependent's medical files transferred to the new PCP.

Receiving Medical Care

When you go to receive medical care:

- Present your Member ID card
- Bring a pen and notepad to write down all questions or concerns you have so that you can get them addressed at one time—ask questions and take notes
- Give your PCP a list of all medicines, vitamins, and supplements that you are taking
- Provide your medical history (including family history) and mention all allergies you may have
- Address any health issues or symptoms you are experiencing

Questions to Ask Your Provider

Asking questions and providing information to your doctor can improve your care. You are encouraged to ask your Providers about your diagnosis, treatments, and medicines in order to improve the quality, safety, and effectiveness of your health care. Here is a list of sample questions that you may use to help you make a list of your own questions:

- What is my diagnosis?
- What are my treatment options?
- What are the benefits of each option? What are the side effects?
- Will I need a test? What is the test for? What will the results tell me?
- What will the medication you are prescribing do? How do I take it? Are there any side effects?
- Do I need to change my daily routine?

Finding a Network Provider

Search our online directory of Network Providers at www.CommunityHealthChoice.org. Our online directory is updated in real time. Please check the online directory before you obtain services to ensure that the Provider is still in our Network.

When searching, be sure to select the correct network for the plan in which you are enrolled. If you do not have access to our online directory, contact Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

Our online directory clearly provides an alphabetical listing of all the physicians and Providers, including specialists. Our online directory also provides a listing for behavioral health and substance abuse treatment Providers. Search our online directory at www.CommunityHealthChoice. org.

Using a Network Provider

In most instances, there are participating Providers available to provide Medically Necessary services. Participating Providers have agreed to accept discounted or negotiated fees. You are responsible for paying the participating Provider for any applicable deductible and/or copayment for services received. We offer different managed care plans, and a provider who participates in one plan may not necessarily be a Participating Provider for other plans offered by Community Health Choice.

USING YOUR **BENEFITS** (CONT'D.)

Seeing a Specialist

Discuss all your medical needs with your PCP. If you and your PCP determine that you need to see a specialist, your PCP should refer you to a specialist in our Provider Network.

We have a wide range of specialists in our Provider Network. Although we allow open access to specialists without a referral from a PCP or authorization from us, some specialists will require a referral from your PCP.

What is a referral? What services need a referral?

A referral is a consultation for evaluation and/or treatment of a patient requested by one doctor to another doctor. View a list of services that need a referral online at www.CommunityHealthChoice.org.

All medical needs should be discussed with your PCP. Although we allow open access to specialty care physicians without a referral from a PCP or authorization from us, some specialty care physicians will require a referral from your PCP. If you and your PCP determine that there is a need to see a specialty care physician, the PCP can recommend one specific to your medical needs.

We do require prior authorization for certain services. Visit our Web site at https://provider.communityhealthchoice.org/resources/prior-authorization-information/ or call the Member Services' telephone number on your Member ID card for a list of services that require prior authorization.

What does "Medically Necessary" mean?

Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Physician or Provider would provide to his/her patient for the purpose of diagnosing, palliating or treating an illness or bodily injury or its symptoms. The fact that a Physician or Provider may prescribe, authorize or direct a service does not make it medically necessary or covered under this illness. Such healthcare service, treatment or procedure must be:

1. In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use;
2. Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
3. Not primarily for the convenience of the patient or Physician or Provider;
4. Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
5. Performed in the most cost-effective setting required by the patient's condition;
6. Supported by the preponderance of nationally recognized, peer-reviewed medical literature, if any, published in the English language as of the date of service; and
7. Not experimental, investigational or for research purposes.


Emergency (Please Specify)
Guardian
Mother
Unknown
No
Yes

FRAUD AND **ABUSE**

If you suspect a Member (a person who receives benefits) or a Provider (e.g., doctor, dentist, counselor, etc.) has committed fraud, waste or abuse, you have a responsibility and a right to report it. You can report Members/Providers directly to Community at:

Community Health Choice
Special Investigations Unit
4888 Loop Central Drive, Suite 600
Houston, TX 77081
1.877.888.0002
siu@communityhealthchoice.org

To file a report online, go to the Texas Department of Insurance (TDI) website at www.tdi.texas.gov/fraud/index.html and select the online reporting forms. If you prefer to talk to a person, call the TDI Fraud Hotline toll-free at 1.800.252.3439. Reports may be

When reporting a Provider (e.g., doctor, dentist, counselor, etc.), have the following information available:

- Name, address, and phone number of Provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Type of Provider (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can aid in the investigation
- Dates of events
- Summary of what happened

When reporting a Member (a person who receives benefits), provide the following information:

- The person's name
- The person's date of birth and social security number or case number if available
- The city where the person resides
- Specific details about the waste, abuse or fraud

NOTICE OF **PRIVACY PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact a Community Privacy Officer.

This Notice of Privacy Practices is given to you as part of the Health Insurance Portability and Accountability Act (HIPAA). It says how we can use or share your Protected Health Information (PHI) and Sensitive Personal Information (SPI). It tells you who we can share it with and how we keep it safe. It tells you how to get a copy of or edit your information. You can allow or not allow us to share specific details, unless needed by law.

Our Responsibility to you Regarding Protected Health Information

"Protected health information" and "sensitive personal information" (PHI/SPI) is information that identifies a person or patient. This data can be your age, address, e-mail address, and medical facts. It can be about your past, present or future physical or mental health conditions. It also can be about sensitive healthcare services and other personal facts.

BY LAW, COMMUNITY MUST:

- Make sure that your PHI/SPI is kept private.
- Give you this notice of our legal duties and privacy practices. It describes the use and disclosure of your PHI/ SPI. Follow the terms of the notice in effect now.
- Tell you about any changes in the notice.
- Notify you that your health information (PHI/SPI) created or received by Community is subject to electronic disclosure.
- Give you an electronic copy of your record within fifteen (15) days after you ask in writing. We can also give this to you another way if you ask for it. There are some exceptions to this rule.
- With exceptions, not sell any PHI/SPI.
- Disclose any breach of unencrypted PHI/SPI we think an unauthorized person might have.
- Ensure that the information you share with us is confidential and secure. We protect your information using Secure Socket Layers (SSL), a process that allows only authorized personnel to access your personal information. All authorized personnel must abide by Community's security and confidentiality policies. Access to your information is restricted based on the employee's responsibilities.
- Train employees about our privacy practices. HIPAA training is required prior to viewing PHI/SPI. Employees are trained annually.

We have the right to change this notice. You may get a copy at www.CommunityHealthChoice.org or call our privacy officer and ask for a copy to be mailed to you.

NOTICE OF **PRIVACY PRACTICES** (CONT'D.)

How Community Can Use or Disclose Your Protected Health Information Without Your Authorization

Here are some examples of allowed uses and disclosures of your PHI/SPI. These are not the only ones.

TREATMENT — Community will use and share your PHI/SPI to provide, coordinate or manage your health care and other services. We might share it with doctors or others who help with your care. In emergencies, we will use and share it to get you the care you need. We will only share what is needed. Community and its representatives will not knowingly cause or permit the use or distribution of enrollee information that is untrue or misleading.

PAYMENT — We can use and share your PHI/SPI to get paid for the healthcare services that you received.

HEALTHCARE OPERATIONS — We can use or share your PHI/SPI in our daily activities. For example:

- To call you to remind you of your visit
- To conduct or arrange other healthcare activities
- To send you a newsletter
- To send news about products or services that might benefit you
- To give you information about treatment choices or other benefits

BUSINESS ASSOCIATES — We can share your PHI/SPI with our business associates. They must also protect it. They must follow HIPAA privacy and security rules, HITECH rules, and Texas Privacy Laws. They can face fines and penalties. They have to report any breaches of unencrypted PHI/SPI.

REQUIRED BY LAW — By law, sometimes we must use or share your PHI/SPI. Here are some examples for Public Health Authorities:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report problems with medicines or other products
- To notify authorities if we believe a patient has been the victim of abuse, neglect or domestic violence

COMMUNICABLE DISEASES — We can share your PHI/SPI to tell a person they might have been exposed to a disease. We can tell a person they might be at risk for getting or spreading a disease or condition.

HEALTH OVERSIGHT AGENCIES & U.S. FOOD AND DRUG

ADMINISTRATION — We will share your PHI/SPI when health oversight agencies ask for it.

LEGAL PROCEEDINGS — We will share your PHI/SPI for legal matters. We must receive a legal order or other lawful process.

LAW ENFORCEMENT & CRIMINAL ACTIVITY — We will share your PHI/SPI if we believe it helps solve a crime. We will share it to stop or reduce a serious threat. We can also share it to help law enforcement officers find or arrest a person.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATIONS — We share PHI/SPI with coroners, medical examiners, and funeral directors. We can also share it to help manage organ, eye or tissue donations.

RESEARCH — If Community agrees to be part of an approved research study, we will make sure that your PHI/SPI is kept private.

MILITARY ACTIVITY AND NATIONAL SECURITY — We can share PHI/SPI of armed forces personnel with the government.

WORKERS' COMPENSATION — We will share your PHI/SPI to follow workers' compensation laws and similar programs.

INMATES — We can use or share your PHI/SPI if you are a correctional facility inmate and we created or received your PHI/SPI while providing your care.

DISCLOSURES BY THE HEALTH PLAN — We will share your PHI/SPI to get proof that you are able to get health care. We will work with other health insurance plans and other government programs.

PARENTAL ACCESS — We follow Texas laws about treating minors. We follow the law about giving their PHI/SPI to parents, guardians or other persons with legal responsibility for them.

FOR PEOPLE INVOLVED IN YOUR CARE OR PAYMENT FOR

YOUR CARE — We will share your PHI/SPI with your family or other people you want to know about your care. You can tell us who is allowed or not allowed to know about your care. You must fill out a form that will be part of your medical record.

RESTRICTIONS ON MARKETING — The HITECH Act does not let Community receive any money for marketing communications.

OTHER LAWS THAT PROTECT HEALTH INFORMATION —Other laws protect PHI/SPI about mental health, alcohol and drug abuse treatment, genetic testing, and HIV/AIDS testing or treatment. You must agree in writing to share this kind of PHI/ SPI.

NOTICE OF **PRIVACY PRACTICES** (CONT'D.)

Your Privacy Rights with Respect to Your Health Information

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION — In most cases, you have the right to look at your PHI/SPI. You can get a printed copy of the record we have about you. It can also be given to you in electronic form. There might be a charge for copying and mailing.

RIGHT TO AMEND YOUR HEALTH INFORMATION — You can ask Community to change facts if you think they are wrong or not complete. You must do this in writing. We do not have to make the changes. If we deny your request, we will do so within sixty (60) days.

RIGHT TO AN ACCOUNTING OF DISCLOSURES — You can ask for a list of certain disclosures of your PHI/SPI. The list will not include PHI/SPI shared before April 14, 2003. You cannot ask for more than six (6) years. The list can only go back three (3) years for electronic PHI/SPI. There are other limits that apply to this list. You might have to pay for more than one list a year.

RIGHT TO ASK FOR RESTRICTIONS — You can ask us to not use or share part of your PHI/SPI for treatment, payment or healthcare operations. You must ask in writing. You must tell us (1) PHI/SPI you want restricted; (2) if you want to change our use and/or disclosure; (3) who it applies to (e.g., to your spouse); and (4) expiration date.

If we think it is not best for those involved, or cannot limit the records, we do not have to agree. If we agree, we will only share that PHI/SPI in an emergency. You can take this back in writing at any time.

If you pay in full for an item or service, you can ask a Provider to not share PHI/SPI with Community for payment or operations purposes. These are the main reasons we would need it. This does not apply if we need the PHI/SPI for treatment purposes.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS — You can tell us where and how to give you your PHI/SPI. You can ask us to only call a certain number. You can also give us another address if you think sending mail to your usual address will put you in danger. You must be specific and put this in writing.

RIGHT TO CHOOSE SOMEONE TO ACT FOR YOU — If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has this authority and can act for you before we take any action.

RIGHT TO A COPY OF THIS NOTICE — You can ask for and get a copy of this notice from us at any time, even if you have received this notice previously or agreed to receive this Notice electronically.

RIGHT TO WITHDRAW AN AUTHORIZATION FOR DISCLOSURE — If you have let us use or share your PHI/SPI, you can change your mind at any time. You must tell us in writing. In some cases, we might have already used or shared it.

RIGHT TO BE NOTIFIED OF BREACH — You will be told if we find a breach of unsecured PHI/SPI. The breach could be from either Community or a business associate of Community.

Federal Privacy Laws

This Notice of Privacy Practices is given to you as part of HIPAA.

There are other privacy laws that also apply. Those include the Freedom of Information Act; Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act; the Health Information Technology for Economic and Clinical Health Act (HITECH); and the Texas Privacy Law, Health, and Safety Code, Section 181 et al.

Complaints

You can file a complaint if you believe your privacy rights have been violated. You can call Community's privacy officer at 1.877.888.0002. You can also file a complaint with the Department of Health and Human Services, Office of Civil Rights. Please refer to the Office of Civil Rights contact information at the end of this Notice. We urge you to tell us about any privacy concerns. You will not be retaliated against in any way for filing a complaint.

Authorization to Use or Disclose Health Information

Other than as stated above, we will not use or share your PHI/SPI without your written agreement. You can change your mind about letting us use or share your PHI/SPI at any time. You must tell us in writing.

The HITECH Act makes Community limit uses, disclosures, and requests of your PHI/SPI. We cannot ask for or share more than is needed.

EFFECTIVE DATE — This notice originally took effect on April 14, 2003, and was updated September 23, 2013. This notice stays in effect until another notice replaces it.

Contact Information

If you have any questions or complaints, please direct your complaint to:

Community Health Choice
Special Investigations Unit
4888 Loop Central Drive, Suite 600
Houston, TX 77081
1.877.888.0002

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 1.877.696.6775
www.hhs.gov/ocr/privacy/hipaa/complaints

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

FREQUENTLY ASKED **QUESTIONS**

Can I only enroll during open enrollment?

Enrollment in Community's Marketplace plans is only allowed during the federally specified open-enrollment period, unless you have a qualifying event. Qualifying events may include but are not limited to:

- Loss of minimal coverage
- Loss of CHIP or Medicaid coverage
- Marriage/birth/adoption
- Gaining citizenship or qualifying immigration status
- Enrollment errors made by CMS or the Marketplace
- Change in eligibility for tax credits or cost-share reductions
- Gaining access to new plans as a result of a move
- If you were enrolled in non-qualifying employer coverage
- If the qualified health plan violates their contract
- Exceptional circumstances

How is age calculated?

Age is determined by the age of the enrollee on the effective date of coverage.

Are there pre-existing condition limitations?

No, there are no pre-existing condition limitations.

How do I locate Network Providers and facilities?

Search our online directory of network Providers at www.CommunityHealthChoice.org. Our online directory is updated in real time. Please check the online directory before you obtain services to ensure that the Provider is still in our network. If you do not have access to our online directory, contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email at MemberServices@CommunityHealthChoice.org. Network Providers are not Community's agents. They are independent contractors. Community pays physicians at a contract fee-for-service rate.

What happens if I see an out-of-network provider?

Under the Community plans, there are no benefits for out-of-network services, with the exception of emergencies or services that have received prior approval/preauthorization for medical necessity.

What is a drug formulary?

A drug formulary is a list of preferred medications put together by Community to help you to access quality, cost-effective medications.

What are generic drugs?

Generic drugs are medications that contain the same active ingredients in the same amounts as brand-name drugs. Generics may be a different color, shape, or size. Generic drugs have been approved by the Food and Drug Administration (FDA) as safe and effective. A generic drug can be substituted for a brand-name drug when rated as an equivalent by the FDA and where permitted by law and the prescriber.

How do I make payment?

The initial premium payment may be paid electronically, by check or credit card by phone. All future payments can be made by check, credit card by telephone, electronic payment via My Member Account or as a walk-in payment at an approved vendor. For a list of approved vendors, visit the Community Web site. You can also set-up automatic payments through your My Member Account.

Can I cancel my coverage at any time?

You can cancel when you have a qualifying event or coverage is automatically canceled for non-payment when the grace period runs out.

Can I change plans at any time?

Plans can only be changed during open enrollment, unless you have a qualifying event.

When must I file a claim?

You must file a claim if you receive services outside of our service area that will not be billed to Community by the physician or Provider.

How can I check claim status?

You can check claims status by logging into your My Member Account or by contacting Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email at MemberServices@CommunityHealthChoice.org.



MEMBER SATISFACTION **SURVEY**

On an annual basis, Community will conduct a Member Satisfaction Survey to solicit and respond to Member's suggestions about how Community can best service its membership. The Member Satisfaction Survey results are viewed by Community's Quality Improvement Committee and reported to Community's Board of Directors. The Member Satisfaction Survey results are available to Members upon request.

THANK **YOU**

Thank you for selecting Community Health Choice as your Marketplace plan! We strive to give you the best service and the best access to healthcare possible.



LANGUAGE ASSISTANCE

Community Health Choice is required by federal law to provide the following information.

COMMUNITY HEALTH CHOICE

NON-DISCRIMINATION STATEMENT

Discrimination is Against the Law

Community Health Choice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community Health Choice does not exclude or treat people differently because of race, color, national origin, age, disability or sex.

Community Health Choice:

- Provides free aids and services to people with disabilities so that they can 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

Community Health Choice also trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes.

If you need these services, contact our Member Services Department.

DSNP: Local: 713.295.5007 | Toll-Free 1.833.276.8306 | TTY: 711

STAR+PLUS: Local: 713.295.2300 | Toll-Free: 1.888.435.2850 | TTY: 711

STAR/CHIP: Local: 713.295.2294 | Toll-Free: 1.888.760.2600 | TTY: 711

Marketplace: Local: 713.295.6704 | Toll-Free 1.855.315.5386 | TTY: 711

If you believe that Community Health Choice 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:

Community Health Choice
Attn: Service Improvement Department
4888 Loop Central Drive, Suite 600
Houston, Texas 77081

Phone: 713.295.2222 TDD/TTY 711
Fax: 713.295.2293
Email: ServiceImprovement@CommunityHealthChoice.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, call Member Services or email MemberServices@CommunityHealthChoice.org.

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, D.C. 20201

Phone: 1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Arabic

تنبيه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا.

Chinese (Simplified)

请注意：如果您说的不是英语，你可以免费获得语言协助服务。

English

ATTENTION: If you speak a language other than English, language assistance services are available to you free of charge.

French

ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique sont à votre disposition gratuitement.

German

WICHTIGER HINWEIS: Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen kostenlose Sprachunterstützungsdienste zur Verfügung.

Gujarati

સૂચના: જો તમે અંગ્રેજી સિવાયની કોઈ અન્ય ભાષા બોલો છો, તો ભાષા સહાય સેવાઓ તમારા માટે નિ: શુલ્ક ઉપલબ્ધ છે.

Hindi

ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं।

Japanese

注意: 英語以外の言語をご希望の方は、ランゲージ アシスタント サービスを無料でご利用いただけます。

Korean

주의: 영어가 아닌 다른 언어를 사용하실 경우, 무료로 언어 지원 서비스를 이용할 수 있습니다.

Lao

ໂປດຊາບ:
ຖ້າທ່ານເວົ້າພາສາອື່ນນອກເໜືອຈາກພາສາອັງກິດ ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ແກ່ທ່ານໂດຍບໍ່ເສຍຄ່າ.

Persian

توجه: اگر به زبانی غیر از انگلیسی صحبت می‌کنید، خدمات کمک زبانی بدون هزینه در دسترس شما است.

Russian

ВНИМАНИЕ: если вы не говорите на английском, для вас доступны бесплатные услуги переводчика.

Spanish

ATENCIÓN: si usted habla un idioma que no sea inglés, hay servicios de asistencia lingüística gratuitos disponibles para usted.

Tagalog

PAALALA: Kung nagsasalita ka ng wika maliban sa Ingles, may magagamit kang mga libreng serbisyo ng tulong sa wika.

Urdu

توجہ: اگر آپ انگریزی کے علاوہ کوئی اور زبان بولتے ہیں تو آپ کے لیے زبان میں مدد کی خدمات مفت دستیاب ہیں۔

Vitenamese

CHÚ Ý: Nếu quý vị nói một ngôn ngữ khác ngoài tiếng Anh, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.

NOTES

NOTES

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CommunityHealthChoice.org

713.295.6704 | 1.855.315.5386

COMMUNITY HEALTH CHOICE