Health Insurance Marketplace

2017 Broker Training
Housekeeping

• Please turn off cell phones
• Presentation is attached to the calendar invite and will be emailed to all participants after the conclusion of the presentation
• Currently appointed agents/agencies must complete a 2017 agreement addendum
• 2017 agency/agent paperwork is available for non-appointed agents/agencies
• All agents must complete quiz
• Any completed paperwork can be submitted at the designated alpha table after the presentation
  ▪ Currently appointed agents/agencies – complete the addendum
  ▪ Non-Appointed agents/agencies – complete the agreement
• Get an Agent of Record form at the point of enrollment or renewal!
Agenda

• Who is Community
• Broker Appointment & Agreement Changes
• 2016/2017 Community Improvements
• Broker Portal Enhancements
• Payments, Billing Cycle and Grace Period
• Plans and Benefits and Rates
• Service Area and Network
• Enrollment
• Q&A
Who is Community?

- We are a local, non-profit Health Maintenance Organization started by Houstonians for Houstonians.
- Affiliate of the Harris Health System
- Serve over 375,000 Members with the following programs:
  - **Medicaid**: State of Texas Access Reform (STAR) program for low-income children and pregnant women
  - **CHIP**: Children’s Health Insurance Program for the children of low-income parents—includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR
  - **ERS**: KelseyCare powered by Community Health Choice HMO offering to the State of Texas Employee Retirement System.
  - **Health Insurance Marketplace Plan**: that offers premium assistance and cost sharing reductions for individual health coverage that includes preventive care, emergency services, prescription drugs, and hospitalization available to all, regardless of pre-existing conditions
Mission Statement

Our mission is to improve the health and well-being of underserved residents of Southeast Texas by opening doors to coordinated, high quality, affordable health care and health related social services.

Our mission is achieved through:

**Community**: Collaborating with community-based Providers and organizations to improve access, quality, coordination and cost effectiveness of services

**Health**: Developing programs to establish medical homes, manage health conditions and promote wellness and preventive care

**Choice**: Encouraging personal accountability and educated choices for individual and family health and well-being
BROKER APPOINTMENT AND AGREEMENT CHANGES
Broker Appointment

• Must complete annual CMS certification for individual Marketplace
• Must complete annual Community training and complete a quiz with a score of 80% or higher
• Must have an active TDI license
• Must hold an active Errors & Omissions Policy
• Must comply with all state and Federal regulatory requirements
• Must supply a W9 that corresponds to tax filing address
Broker Agreement Changes for 2017

• Addendum to existing agreement to be completed by all existing agents or officer of agency
  ▪ Must be signed, dated, and submitted before actively selling business for 2017

• Addendum Updates Include:
  ▪ Errors and Omissions policy must cover all active agents under the agreement
  ▪ Compensation: based on amount and schedule established and communicated annually
    □ 2017 - $15 per member per month
Broker Agreement Changes for 2017 continued

- Agent/Agency must keep records for a period of 10 years as required by CMS
- Agent/Agency must comply with all applicable state and federal laws regarding solicitation of business including all state and federal confidentiality conflict of interest laws, rules and regulations
- Agent/Agency agreement will automatically renew each year unless terminated in writing
- Agent/Agency must complete Community’s annual agent/agency training
2016/2017 IMPROVEMENTS
2016/2017 Improvements

- Added new employees
- Leased new space – Opening November 2016 (Beltway and Clay Rd.)
- Improved phone line functionality
- Added vendor call overflow
- Created an eligibility department with billing oversight
- Opened Community Cares Center
- New & Improved Member Welcome Packet
- Additional Payment Notifications – New 2017
  - Insufficient funds, unable to draft fund notification
  - Upcoming transaction notification
  - Transaction completion notification
- Created Broker ACH for auto commission payments
- Improved Commission auditing, reporting, and statements
- New Sales Line – 713.295.6760, Agent Relations Email: AgentRelations@CommunityCares.com
- Improved Broker Portal functionality
BROKER PORTAL ENHANCEMENTS
Broker Portal Enhancements

- Added client search functionality
  - Search by name
  - Search by subscriber ID
Broker Portal Enhancements

- Added paid through date

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Broker Portal Enhancements

- Added last payment date
- Added paid through date
Broker Portal Enhancements

- Added personalized broker URL link

Community Health Choice gives you the ability to create a personalized URL to link to your broker profile. Giving this link to your clients will allow them to enroll under your NPN, giving you credit for the enrollment.

PAYMENTS, BILLING CYCLE & GRACE PERIOD
Softheon Billing and Enrollment System

- Softheon is a cloud-based service that is responsible for handling Community’s enrollments and invoicing needs, including the broker enrollment portal.

**Enrollment:**
- Softheon receives all of our enrollment from CMS.
- Enrollment for off-exchange is processed direct through Softheon.
- Community **only receives** the effectuated files (members who have paid their first premium) who are then loaded into the eligibility and claims payment systems.
- Members will not receive materials including Member Welcome Packets, or ID cards until the member has effectuated coverage.
Payments

• Once a member enrolls in a Community plan they will be able to make their initial payment and any ongoing payments:
  ▪ Online via our website
  ▪ Pay-by-phone by calling Community directly
    o option or speak to a representative
    o option to pay by IVR payment prompts without speaking to an individual
  ▪ Mailed money order or check to address on billing statement (must include subscriber ID or monies cannot be applied)

• Forms of Payment Accepted:
  ▪ Check
  ▪ Credit card (Visa/Mastercard/Discover)
  ▪ Debit card
  ▪ Money Order

• After members have made their initial binder payment, they can set up re-occurring payments online. Payments will be deducted the first or last day of each month from the established account

• Members who are set up on re-occurring payments for 2016 that renew for 2017 will be required to re-establish re-occurring payments. The last cycle of re-occurring payments will be deducted on December 1, 2016.
Online Payment Options

Members have the option of making a quick payment without having to create an account by using the quick pay link on the member portal. Subscriber ID is required, or member may be able to locate the subscriber ID with the lookup function.

https://memberportal.communitycares.com/English/MemberLoginHIM.aspx
Members have the option of setting up re-occurring payments by creating an online account after the initial binder payment is made and applied to their account.

To complete an online account the member will need to enter a Member ID which can be found on their member ID card.

- Members with online accounts can view claims, EOB’s, manage re-occurring payments, print ID cards and update account information.
Billing Cycle and Grace Period

- Members premiums are due by the last day of the month prior to the coverage month
  - e.g. If member is effective 01/01/17, premium is due by 12/31/16
- Payments not received by the last day of the month prior to the coverage month are considered late
- Terminations are processed on the 5th of each month
- Members who have APTC receive a 90 day grace period only after the binder payment has been made to effectuate coverage
- Members who do not have APTC receive a 30 day grace period only after the binder payment has been made to effectuate coverage
Billing and Enrollment Terminology

• **Passive Enrollment** – An enrollment where the member remains with the same Qualified Health Plan under the same plan.

• **Grace Period** – A timeframe given to members to allow the member to pay all past due amounts to avoid being terminated for non payment. **Note:** Grace period only applies to effectuated policies.

• **Binder Payment** – The initial payment required to effectuate coverage for the first month of the policy.

• **Effectuate** – A policy is considered effectuated when the binder payment is made in full to activate policy.

• **Policy Rate Amount** – The standard rate for all members. The policy rate amount is based on age, tobacco user, plan selected and rating area.

• **APTC (Advanced Premium Tax Credit)** – Financial assistance (subsidies) provided by the Federal Government given to individuals who apply for coverage through HC.gov and meet all qualifications. The amount varies from family to family.
  - Families applying for APTC should list head of household as the subscriber.
  - Individuals receiving APTC must file income tax return.
  - Individuals who provide inaccurate or incomplete information are subject to penalties and may owe back all subsidy received.
Billing and Enrollment Terminology Continued

- **CSR (Cost Share Reduction)** – A reduction of cost for health benefits for individuals who are enrolled in a qualified silver plan. Health benefits include deductibles, coinsurance, copays, or other similar charges (does not apply to premium). Members qualify for CSR based on income reported.

- **Past Due Amount** – The amount the member owes for months that were not paid by the due date.

- **Paid Through Date** – The date in which the member has made timely payments. Note: The Paid through date does not roll over if a partial payment is made.

- **Claims Paid Through Date** – The date calculated for APTC members, the calculated date is the Paid through date + 1 month. The Claims Paid Through Date will not be greater than the termination date.

- **Finance Paid Through Date** – The date calculated for members solely based on premiums and payments. The Finance Paid Through Date does not look at whether the payment was made on time.
Recap

• APTC Members receive a 90 day grace period

• Non-APTC Members receive a 30 day grace period

• Grace period **does NOT** roll over, the member must pay all past due premium amounts to exit the grace period before the end of the grace period cycle
Scenario 1 - APTC
Did not pay timely

- Member enrolled with 01/01 effective date
- Member makes binder payment 12/28
- Member does not make Feb payment by due date 01/31, member goes into grace period 02/01
- Member does not make March payment by due date 02/28, member is now in second month grace and owes two month’s premium
- Member does not make April payment by due date 03/31, member is now in third month of grace and owes 3 full months premium by 04/30 to prevent termination. Partial payments do not take a member out of grace.
- If member does not pay, policy is terminated back to 02/28
Broker Delinquent Member Report

- Identifies delinquent clients as well as days in grace period
- To subscribe to this report send an email to: AgentRelations@CommunityCares.com with the subject line: Broker Delinquent Member Report Request
PLANS AND BENEFITS
## Plan Types

<table>
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<th>Levels of Coverage</th>
<th>Plan Pays on Average</th>
<th>Enrollees Pay on Average (In addition to the monthly plan premium)</th>
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<td>Catastrophic*</td>
<td>&lt;60 percent*</td>
<td>&lt;40 percent*</td>
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<tr>
<td>Bronze</td>
<td>60 percent</td>
<td>40 percent</td>
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<tr>
<td>Silver</td>
<td>70 percent</td>
<td>30 percent</td>
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<tr>
<td>Gold</td>
<td>80 percent</td>
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<tr>
<td>Platinum*</td>
<td>90 percent*</td>
<td>10 percent*</td>
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<tr>
<td>Simple Choice</td>
<td>Standardized plans that have similar benefit designs predetermined by CMS.</td>
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*Community will not be offering a Platinum Plan, Catastrophic Plan, or Simple Choice Plans.
Financial Assistance

- Advanced Premium Tax Credits (APTC) Subsidies:
  - Available to consumers between 100% - 400% Federal Poverty Level (FPL)
  - Based on income relative to second lowest-priced silver plan in the area

- In Texas:
  - 83.6% enrollment with APTC
  - 59.6% enrollment with Cost Sharing Reduction (CSR)

- COMMUNITY:
  - 83.6% enrollment with APTC
  - 59.1% enrollment with CSR
Cost Sharing Reductions (CSRs)

- Health plans cover a higher percentage of out-of-pocket costs for people with low/modest incomes.

- Only available to individuals between 100% - 250% FPL.

- Consumers must enroll in a Silver plan.
Cost Sharing Reduction Plans

• Enrollees <250% Federal Poverty Level (FPL) are eligible for Cost Sharing Reduction (CSR) plans

• **Only Silver level plans have CSR benefits**

• Cost Sharing Reductions mean reduced copays, coinsurances, and lower out-of-pocket maximums

• There are 3 Silver CSR plans:
  • Silver 73 = 201-250% FPL
  • Silver 87 = 151-200% FPL
  • Silver 94 = 100-150% FPL

• If a potential enrollee earns <100% FPL, they are not eligible for CSR plans
Limited and Zero Cost Sharing Plans

In addition to the 3 Silver CSR plans, there are Limited and Zero Cost Sharing options that are available to Native Americans:

**Zero Cost Sharing Plans**
- Native Americans, 100-300% FPL and qualify for APTC
- Pay $0 copays or 0% coinsurance
  - Gold Zero Cost Sharing
  - Silver Zero Cost Sharing
  - Bronze Zero Cost Sharing

**Limited Cost Sharing Plans**
- Pay $0 copays or 0% coinsurance at Indian Health Service Providers* only
  - Gold Limited Cost Sharing
  - Silver Limited Cost Sharing
  - Bronze Limited Cost Sharing

*There are currently no Indian Health Service Providers in our service area

[https://www.healthcare.gov/glossary/limited-cost-sharing-plan/](https://www.healthcare.gov/glossary/limited-cost-sharing-plan/)
2017 – Number of Insurers

Source: Kaiser Family Foundation
2017 On-Exchange Enrollment Options by County

• Harris County:
  ▪ BCBS/Community/Molina

• Jefferson County:
  ▪ BCBS/Christus/Community/Molina

• All other Community Counties (Brazoria/Chambers/Fort Bend/Galveston/Liberty/Montgomery/Orange/Waller):
  ▪ BCBS/Community
Open Enrollment Timeline

November 1, 2016: Open enrollment starts

December 15, 2015: Last day to enroll for coverage to start in January.


January 31, 2017: Last day to enroll in or change a 2017 health plan.
Special Enrollment Period (SEP)

Consumers may qualify based on the following:

1. Loss of qualifying health coverage
2. Change in household size
3. Change in primary place of living
4. Loss of CHIP or Medicaid coverage
5. Change in eligibility for Marketplace coverage or help paying for coverage
6. Enrollment or plan error
7. Other qualifying changes: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

- Online Enrollment Portal (including broker portal enrollment) shuts down on 02/01/17
- Off Exchange SEP enrollments will follow on-exchange. If enrolled prior to the 15th of the month, coverage is effective first of the month. If enrolled after the 15th of the month, coverage is effective first of the following month unless there is an SEP that would justify a mid month enrollment. E.g. birth of a child
2017- What’s new?!!

• 2 new plans

• Total of 7 plans for 2017

• 5 existing plans being renewed with minimal changes

• 2017 Plans:
  • Community Health Choice HMO 001
  • Community Health Choice HMO 002
  • Community Health Choice HMO 003
  • Community Health Choice HMO 004
  • Community Health Choice HMO 005
  • KelseyCare powered by Community Health Choice HMO 006
  • KelseyCare powered by Community Health Choice HMO 007
## Plan Names Crosswalk

<table>
<thead>
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<th>2016 Plans</th>
<th>2017 Plans</th>
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<td>Gold 001 (Copay)</td>
<td>Gold 001 (Copay)</td>
</tr>
<tr>
<td>Silver 002 (Copay)</td>
<td>Silver 002 (Copay)</td>
</tr>
<tr>
<td>Bronze 003</td>
<td>Bronze 003</td>
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<tr>
<td>Silver 004 (Deductible)</td>
<td>Silver 004 (Deductible)</td>
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<tr>
<td>Gold 005 (Deductible)</td>
<td>Gold 005 (Deductible)</td>
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<tr>
<td>Gold 006 (Copay - Kelsey only)</td>
<td>Gold 006 (Copay - Kelsey only)</td>
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<tr>
<td>Silver 007 (Copay - Kelsey only)</td>
<td>Silver 007 (Copay - Kelsey only)</td>
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## 2017 Plan Designs Changes

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<th>Member Cost Share</th>
<th>Community Health Choice HMO Bronze Deductible 003***</th>
<th>Community Health Choice HMO Silver Deductible Plans 004**</th>
<th>Community Health Choice HMO Gold Deductible 005**</th>
<th>Community Health Choice HMO Silver Copay 002</th>
<th>Community Health Choice HMO Gold Copay 001</th>
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<td>Medical Deductible (individual/family)</td>
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<td>$1,250/$2,500</td>
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<td>$0</td>
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<td>Out-of-Pocket Max (individual/family)</td>
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<td>$7,150/$14,300</td>
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<td>Copaysurance</td>
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### MEDICAL BENEFITS

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<td>Specialist Office Visit</td>
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<td>Outpatient Facility</td>
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<td>Outpatient Surgery</td>
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<td>Urgent Care Services</td>
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<td>Ambulance Services</td>
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<td>Medical Imaging (CT/PET Scan, MRI)</td>
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### PRESCRIPTION DRUGS

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<td>Preferred Brand</td>
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<td>Non-Preferred Brand</td>
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<tr>
<td>Specialty High Cost Drugs</td>
<td>40% (after $200 deductible)</td>
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Deductible Plans

• Bronze Deductible Plan has 3 PCP Office visits covered at the PCP office visit copay prior to deductible

• With the exception of the 3 PCP visits on the Bronze deductible plans; all deductible plans require the deductible to be met before benefits are paid and copays apply

• Bronze Deductible Plan has a $200 prescription deductible per covered individual

• Deductible plans only have access to the Community Network of Providers

• Specialty high cost drugs have a coinsurance
Copay Plans

- Copays apply to any covered service from day 1
- Inpatient copays apply for the first 5 days of inpatient stay
- Specialty high cost drugs have a coinsurance
- Copay members enrolling in Copay plans HMO Silver 002 or HMO Gold 001 have access to the Community Network
- Copay members enrolling in KelseyCare powered by Community Health Choice HMO Copay plans HMO Silver 007 and HMO Gold 006 have access to KelseySeybold and their affiliate provider network
- Members who are currently enrolled in a copay plan and have selected a KelseySeybold PCP will be required to re-enroll into one of the KelseyCare powered by Community Health Choice plans (HMO Silver 007 of HMO Gold 006) for 2017 or they will loose access to KelseySeybold
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# Rate Increase by Plan

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<td>$321.54</td>
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* Rates listed are non tobacco 40 year old
SERVICE AREA AND NETWORK
Service Area

- No changes made to the Community service delivery area
- 10 county area for existing five plans
- 5 county area for KelseyCare plans

Community SDA (same as 2016)
HMO 001-005

KelseyCare SDA (same as 2016)
HMO 006 and 007
Network Changes for 2017

IMPORTANT

- HMO 001,002,003,004,005 will have access to the Community network of providers
- HMO 006 and 007 (New KelseyCare powered by Community Health Choice plans) will ONLY have access to the KelseySeybold network
- HMO 001 and 002 (Copay Plans) WILL NOT have access to the KelseySeybold providers

Note: If a member currently who is currently enrolled into a 2016 Community Copay Plan and has Kelsey as their PCP, wishes to continue utilizing Kelsey in 2017, they must actively re-enroll into KelseyCare powered by Community Health Choice HMO 006 or 007 plans. All 2016 copay plan members will be passively re-enrolled into Community’s copay plans, regardless of their PCP selection.
KelseyCare powered by Community Health Choice HMO 006 and 007 (Silver and Gold)

• KelseySeybold is only available for members choosing a Silver 007 or Gold 006 plan
  • Bronze 003, Silver 002/004, or Gold 001/005 plan members **cannot use** Kelsey Seybold providers

• Available to members in Harris, Montgomery, Fort Bend, Brazoria, and Galveston counties only

• Network will include Kelsey Seybold providers and hospitals.

• Members enrolled into KelseyCare plans **will NOT** have access to Community network.
Community Network Hospitals and Physician Groups

- Hospitals, Physician Groups & Labs
  - Baptist Hospital of Southeast Texas – Orange
  - Baptist Hospital of Southeast Texas – Port Arthur
  - Baylor College of Medicine
  - Brazosport Regional Hospital
  - CHI St. Luke’s Health
  - Harris Health System
  - Huntsville Memorial Hospital
  - Liberty Dayton Regional Medical Center
  - Memorial Hermann Hospital System
  - MHMD Physician Group
  - Oakbend Medical Center
  - St. Joseph Medical Center
  - The Medical Center of Southeast Texas
  - UTMB Health
  - UTMB Health Angleton Danbury
  - UTMB Faculty Group
  - UT Physicians
  - Winnie Community Hospital

- Labs:
  - LabCorp
  - Quest Diagnostics
Network

- Navitus Health Solutions Pharmacy
- Superior Vision (only children 18 and under)
- Beacon Health Strategies Behavioral Health
- Routine dental services are not covered by Community. Enrollees have the option to purchase stand-alone dental plans offered by other companies through the Marketplace
IMPORTANT DOCUMENTS
Evidence of Coverage

• Detailed benefit information is available in the Evidence of Coverage (EOC) on our website. The 2017 EOC will go-live 11/1/2016

• Deductible EOC applies to the three deductible plans
  ▪ HMO Bronze 003, HMO Silver 004, and HMO Gold 005

• Copay EOC applies to the four copay plans
  ▪ HMO Silver 002, HMO Gold 001, HMO Gold 006, HMO Gold 007
Summary of Benefits and Coverage

• Summary of Benefits and Coverage (SBC’s) provides a overview of specifics related to each plan level

• These documents are available on our website (2017 SBC’s will go-live on 11/1/2016)

• SBC’s are mailed to effectuated members within 2 days after receiving files from Softheon as part of the Welcome Packet
ENROLLMENT

Open Enrollment begins November 1, 2016!
On Exchange and Off Exchange

• This year, there are two paths to enrolling in Community Marketplace plans

On Exchange

• Enroll via www.CommunityCares.com
• Enroll via www.healthcare.gov

Off Exchange

• Enroll via www.CommunityCares.com directly from Community’s website (utilizing Softheon’s broker enrollment portal)
On Exchange

- On-Exchange enrollment is no different than last year
- Enrolling On Exchange is the only way a person can get tax subsidies to help pay for their premiums
- On-Exchange plans include the Cost Sharing Reduction plans (CSR plans) – Silver 73%, Silver 87%, and Silver 94% (cannot get Off Exchange)
- On-Exchange plans also include Zero and Limited Cost Sharing plans available to Native Americans (cannot get Off Exchange)
- Changes to on-exchange enrollments including changes to demographics and income must be reported to the Health Insurance Marketplace
- Members who have request for documents, must submit those documents to the Health Insurance Marketplace within the specified time or risk losing subsidy
- Individuals who do not submit an income tax return are not eligible for subsidy but may be eligible for an exemption (depending on income). Individuals receiving subsidy who do not file an income tax return owe back any subsidy received and could be subject to penalties
Off Exchange

• Off Exchange plans are the same as the On Exchange standard Bronze, Silver, and Gold plans
• No CSR (73/87/94) or Limited/Zero Cost Sharing plans available Off Exchange
• Apply through direct enrollment portal on our website (Softheon) or fax in a paper application that is available online
• Open Enrollment dates are same as On Exchange, Special Enrollment Period criteria same as On Exchange
• Account service (including change of information, adding dependents, etc) will go through Community, not CMS
• Only consumers residing within one of our 10 county service area will be allowed to enroll in a Community plan (be mindful there are zip codes falling within 2 counties)
Renewals

• Community members currently enrolled in a 2016 plan will receive two notices regarding 2017 coverage:
  1. One from Community outlining 2016 premiums and benefit changes
  2. One from CMS explaining the open enrollment process
• If a current member takes no action, the member will “passively renew” into a 2017 Community plan
• If a current member takes action and updates their application on healthcare.gov then they will need to select a 2017 plan
• Members wanting to keep KelseySeybold must re-enroll in a KelseyCare powered by Community plan (HMO 006/HMO 007)
Who is eligible to enroll?

- Any individual residing in one of Community’s 10 county service area and their eligible dependents
- Eligible dependents include:
  - Spouse
  - Biological children under the age of 26
  - Stepchildren under the age of 26
  - Adopted children under the age of 26
  - Foster children under the age of 26
  - Brother or Sister (child only policies)
  - Life partner

- Families with more than 3 children enrolled on the same policy under the age of 21 are charged for the first three children only. Any child age 21 to 25 is charged the applicable rate for their age. Any child age 26 or older must be covered on their own policy.
  - e.g. Family enrollment received:
    - Father – charged applicable rate for age band
    - Mother – charged applicable rate for age band
    - Child age 10 – charged under 21 rate
    - Child age 6 – charged under 21 rate
    - Child age 4 – charged under 21 rate
    - Child age 2 – no charge
Member ID Card

![Marketplace ID Card]

- **Member Name:**
- **Plan Name:**
- **Member ID:**
- **Plan ID:**
- **Assigned Provider:**
- **Effective Date:**
- **Co-Payments:**
  - PCP:
  - Urgent Care:
  - Emergency Room:
- **Deductible (Individual/Family):**

**Pharmacy Information:**
- Pharmacy (Nuvitius Health Solutions): BIN: 610602; PCN: NVT; RXGroup: CHX
- Community Member Services (Monday - Friday, 8:00 a.m. - 5:00 p.m.):
  - 713.295.6704 or toll-free at 1.855.315.5386

**Important Information:**
- You may be asked to present this card when you receive care. This card does not guarantee coverage. You must comply with all terms and conditions of the plan. Wilful misuse of this card is considered fraud. In case of an emergency, call 9-1-1 or go to the nearest Emergency Room. Please call your Primary Care Provider as soon as possible for further assistance and directions on follow-up care within 48 hours.

**Inpatient and Outpatient Procedures:**
- Certain services require pre-authorization. Failure to do so may affect benefits. Please refer to your plan documents for your pre-certification requirements.

**Provider Services:**
- 713.295.6704 or toll-free at 1.855.315.5386
- Eligibility, benefits, and claims: Monday - Friday, 8:00 a.m. - 5:00 p.m.
- Authorizations: Monday - Friday, 6:00 a.m. - 6:00 p.m. Weekends and Holidays,
  - 9:00 a.m. - 12:00 p.m.

**Send Claims to:**
- Community Health Choice, Inc. P.O. Box 301424 Houston, Texas 77230
- Electronic claims: Payer ID 60495

**Behavioral Health:**
- 1.855.539.5881
- Pharmacy: 1.866.333.2757
- 24-Hour Nurse Help Line: 1.888.332.2730
Member ID Card (KelseyCare)

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Pharmacy (Navitus Health Solutions): BIN: 610602; PCN: NV7; RXGroup: NVCHX
Community Member Services (Monday - Friday, 8:00 a.m. - 5:00 p.m.): 713.295.6704 or toll-free at 1.855.315.5386

You may be asked to present this card when you receive care. This card does not guarantee coverage. You must comply with all terms and conditions of the plan. Wilful misuse of this card is considered fraud. In case of an emergency, call 9-1-1 or go to the nearest Emergency Room. Please call your Primary Care Provider as soon as possible for further assistance and directions on follow-up care within 48 hours.

Inpatient and Outpatient Procedures:
Certain services require pre-authorization. Failure to do so may affect benefits.
To pre-authorize services, call Kelsey-Seybold at 1.888.684.5283
Provider Services: 713.295.6704 or toll-free at 1.855.315.5386
Eligibility, benefits, and claims: Monday - Friday, 8:00 a.m. - 5:00 p.m.

Send Professional Claims to: Kelsey-Seybold Clinic P.O. Box 841209 Pearland, Texas 77584
EDI Payer # KELSE
For claims questions call, 1.800.215.3573
Send all other Claims to: Community Health Choice, Inc. P.O. Box 301424 Houston, Texas 77230
Electronic claims: Payer ID 60495
Behavioral Health: 1.855.539.5881
Pharmacy: 1.866.333.2757
24-Hour Nurse Help Line: 713.442.0000
Is everyone required to purchase insurance?

- Most individuals are required to purchase insurance or pay penalties. (Penalty for 2016 is the greater of 2.5% of your total family income or $695 per adult and $347.50 per child under 18 to a maximum of $2,085 for family.)

- Exceptions:
  - Individuals covered under an employer sponsored plan
  - Individuals already enrolled in an individual insurance plan meeting all ACA requirements
  - Individuals who are eligible for Medicaid or CHIP
  - Individuals who would have to pay more than 8% of their income for health insurance
  - Individuals below the threshold required to file an income tax return
  - Undocumented Immigrants
  - Individuals who are incarcerated
  - Members of Native American Indian Tribes
  - Full list is available on Healthcare.gov
FAQs

Can someone eligible for group health insurance through an employer apply for individual plans on the Health Insurance Exchange?

• Yes, if group coverage does not meet the minimum essential coverage requirements

• Yes, if the group coverage is unaffordable
  ▪ Cost for single coverage after the employer contribution exceeds 9.5% of household income
What information do I need to enroll?

- Social Security Numbers (or document numbers for legal immigrants)
- Employer and income information for every member of your household who needs coverage (for example, from pay stubs or W-2 forms—Wage and Tax Statements)
- A completed Employer Coverage Tool for every job-based plan you or someone in your household is eligible for. (You’ll need to fill out this form even for coverage you’re eligible for but don’t enroll in.)
FAQs

What happens if I see an out-of-network provider?
• Under the Community Health Choice plans there are no benefits for out of network services with the exception of emergencies or services that have received approval or preauthorization for medical necessity. Please refer to our U&C Policy owned by Claims department for more information.

If my children are currently enrolled in Medicaid and CHIP will they be able to keep it or are they required to be enrolled with me?
• Your children can continue with their Medicaid and CHIP coverage through their eligibility period and are not required to enroll with you. If your children lose their Medicaid or CHIP coverage they can enroll in a Marketplace product at that time.
FAQs

Does deductible count towards out-of-pocket maximum?

• Yes. The out-of-pocket maximum includes copayments, coinsurance, and deductible. The out-of-pocket non-covered services, and other contract limits.
FAQs

What about pre-existing conditions?
• Individuals cannot be denied coverage for a pre-existing condition, nor can they be charged higher premiums for pre-existing conditions.

Does Community require a referral to see a specialist?
• Yes, for HMO 006 and 007 plans only for Kelsey affiliates.

What is included in the welcome packet the member receives after enrollment?
• The welcome packet is sent to the enrollee within 7 days of making their initial payment. It includes a welcome letter, and Summary of Benefits and Coverage. Afterwards, the member receives a second letter including the Member ID card.
FAQs

Will CHC offer reoccurring payment option for members?
• Yes. Members can now set-up reoccurring payments through the Softheon/Community portal.

What frequency will members need to pay premiums?
• Monthly.

Will Community offer credit card payments?
• Yes, members may pay with credit card online or by phone.
FAQs

Why do I see staggered enrollment effective dates for members?
• If a member enrolls before the 15th of a month, their effective date will be on the first of the following month.
• If a member enrolls after the 15th of a month, they will not be eligible to have an effective date on the first of the following month.
• Issuer should expect to see dates other than the first of the month for enrollees since different enrollments have different effective dates.
• This is specially true for HICS/SEP cases

Are babies covered?
• Community will cover a newborn for the first 31 days of life. Coverage for a newborn or adopted child beyond 31 days will be effective on the date of the birth, placement, adoption, or date the court grants the petition for adoption, provided the subscriber completes an application and pays the premium within 31 days of the child’s date of birth or adoption. Same On and Off Exchange.
FAQs

Are routine eye exams for children and eyeglasses for children covered for children 18 and under or 21?

• Routine eye exams and eyeglasses are covered for children 18 (until they turn 19)
Glossary

Deductible
• The amount you owe for health care services before your health insurance plan begins to pay.

Co-payment
• A fixed amount you pay for a covered health care service.

Co-insurance
• Your share of the costs of a covered health care service after the deductible has been met. After you have met your deductible you begin paying a percentage of the allowed amount for most covered medical services and supplies until you reach our annual out-of-pocket maximum.

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.
Primary Care Physician
• A primary care physician (PCP) is trained to manage your entire health care program. Your PCP plays many roles – primary care giver, health care advisor and consultant, coordinator of specialty care, patient advocate, and medical home. PCP’s 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)

Specialist
• A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. Examples of specialists include:
  • Cardiology
  • Dermatology
  • Surgery

Network
• Doctors, hospitals, and other health care providers who have a contract with CHC to provide services at a negotiated rate of payment.
Glossary

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).

Preauthorization

- A medically necessary healthcare service, treatment plan, prescription drug, or medical equipment that requires you or your provider to obtain approval or precertification prior to receiving services, except in an emergency.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<td>November 1, 2016</td>
<td>Open Enrollment Begins</td>
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<td>December 15, 2016</td>
<td>Last day to enroll for 1/1/2017 effective date coverage</td>
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<tr>
<td>January 1, 2017</td>
<td>2017 Health Coverage Begins</td>
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Questions