HEALTH INSURANCE MARKETPLACE

MEMBER HANDBOOK

AND DISCLOSURE INFORMATION 2016

CommunityHealthChoice.org

713.295.6704 | 1.855.315.5386

COMMUNITY HEALTH CHOICE

COMMUNITY CARES.

IMPORTANT PHONE NUMBERS

1.855.315.5386	Member Services 8:00 a.m. – 6:00 p.m., Monday – Friday, (excluding federal-approved holidays.)	713.295.2294

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

7-1-1	TDD for Hearing-Impaired	
1.888.332.2730	24-Hour Nurse Help Line	
1.866.333.2757	Pharmacy (Navitus Health Solutions)	
1.877.935.5797	Mail-Order Pharmacy (Wellpartner)	Wellpartner.com
1.800.879.6901	Vision (Superior Vision)	
1.855.539.5881	Behavioral Health/Substance Abuse Services (Beacon Health Options)	
1.855.315.5386	Provider Services (Eligibility/Authorizations/Benefits/Claims)	713.295.6704
1.877.888.0002	Waste, Abuse or Fraud Hotline	

Write or visit us at:
Community Health Choice, Inc.
2636 South Loop West, Suite 125
Houston, TX 77054
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** our community. With Community, you'll have a **TRUSTED** friend who respects you and your family, provides access to high quality healthcare, 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. It is not an all-inclusive document. It is a companion piece to the **Evidence of Coverage** and the **Summary of Benefits and Coverage**. Please read all of these documents carefully for information about your coverage. All documents are online at CommunityHealthChoice.org. Upon request, they can be mailed to you. Contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@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 a document that 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) is a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help you better understand the coverage you have and allow you to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Member Services

Call Community Member Services for help at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org. Our hours are 8:00 a.m. – 5:00 p.m., Monday - Friday, excluding state-approved holidays. We speak English, Spanish or can get you an interpreter who speaks your language. Community Member Services can help you:

- understand your benefits
- choose a primary care provider
- change your primary care provider
- locate a specialist
- send you a new identification card if yours is lost or stolen
- solve complaints or problems

Covered Services

Covered Services

Covered health care 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 CommunityHealthChoice.org.

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 services please review the Evidence of Coverage or contact Member Services for the list at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@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 healthcare
- 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
- Preventative care services
- Reconstructive surgery
- Skilled nursing facility and rehabilitative services
- Transplant services, transplant transportation and lodging
- Urgent care
- Pediatric vision services

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 CVS, Walgreens, Target, Wal-Mart, and others. A complete list of participating pharmacies is available on their Web site 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. Navitus also provides a useful Member Guide that we have placed on our Web site at http://www.CommunityHealthChoice.org/en-us/Member-Resources/Health-Insurance-Marketplace under "Important Health Insurance Marketplace Member Documents."

A mail-order program is included in your pharmacy benefit. Mail-order benefits are provided through Wellpartner Mail Order Pharmacy. By participating in the mail-order program, you can have up to a ninety (90)-day supply mailed directly to your home or office. To enroll online, go to Wellpartner.com and choose "Mail Order Pharmacy" or call Wellpartner toll-free at 1.877.935.5797.

Prescription Drug Coverage

Community has a preferred drug list that provides the details and level copays for each covered drug. You are required to pay all deductibles or copays for the level copay amount listed on the Summary of Benefits. View a copy of this list online at CommunityHealthChoice.org. You may also request a copy from our Member Services Department. Contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org.

Vision

Marketplace members under 18 years of age are eligible to receive an eye exam and corrective eyewear once per year. Please contact Superior Vision toll-free at 1.800.879.6901.

Behavioral Health

How do I get help if I have behavioral (mental) health, alcohol or drug problems?

If you or your dependent has a problem with drugs, alcohol or mental health, call Beacon Health Options toll-free at 1.877.343.3108, the Community Provider of mental health and drug and alcohol abuse treatment services. You can call Beacon Health Options 24 hours a day, seven days a week. Information is available in English and Spanish. Call us to get an interpreter. 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 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 Beacon Health Options.

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:

https://www.healthcarebluebook.com/

http://www.webmd.com/

https://www.urac.org/resource-center/consumers/tools-for-patients/

Value-Added Programs

24-Hour Nurse Help Line

You can call the Community Nurse Help Line 24 hours a day, seven days a week toll-free at 1.888.332.2730. Call the Nurse Help Line before going to the emergency room, if you are unsure whether or not your condition warrants that visit.

A nurse will answer your health care questions and help you get the care you need. Specially-trained nurses can answer questions related to your health and give you information when your doctor is not available that will help you choose the proper level of care based on your symptoms.

The Nurse Help Line does not take the place of your doctor. Always follow up with your doctor, if you have questions about your health care.

Care Management Program

Our Care Management team focuses on the coordination of health care 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, COPD, diabetes or those who may have problems with maintaining a healthy weight. We also help Members who may have trouble coordinating their care. Call our Care Management department at 713.295.2303 or toll-free at 1.844.297.4450 to join.

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

Emergency, After-Hours Care, Non-Network Providers and Out-of-Area Services

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

An emergency medical condition means your symptoms are severe and sudden. An average person with average knowledge of health and medicine could expect that you would place your health or life in jeopardy by not getting help right away. For pregnant women, this includes unborn children.

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 your admission, 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 in other than an emergency which 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 to lead a prudent layperson, possessing an average knowledge of medicine and health, 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 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 Marketplace@CommunityHealthChoice.org.
3. You must receive any follow-up services from your PCP or a Network Provider.
4. You must pay any deductible and/or copayment required for urgent care.

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

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

Using a Non-Network Provider

Community provides use of Non-Network Providers for:

- emergency care when medically necessary
  or
- if covered services are not available through our Network Providers

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

Not all healthcare practitioners 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. Non-Network Providers may require payment from you for any amount not paid by Community.

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 (regardless of what the referring provider may have told you), you will be responsible for all costs incurred, unless we have authorized the services provided.

Search our online directory of Network Providers at 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 Marketplace@CommunityHealthChoice.org.

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

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.

Return to our service area for follow-up care when you are well enough.

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, include the following information with your claim.

1. Proof of payment to the foreign provider for the services provided
2. Complete medical information and/or records
3. Proof of travel to the foreign country, such as airline tickets or passport stamps
4. The foreign provider's fee schedule if the provider uses a billing agency

Community will acknowledge that we received the claim within fifteen (15) days, and we will investigate. 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, notify us of your new residence and phone number. 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 as of the due date, your policy may be terminated. All payments received after the 5th 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 Member portal
- Cash payment at one of Community's preferred vendors listed on our Web site
- Paper check or money order mailed directly to Community Health Choice

Paper checks or money orders should be made payable and mailed to:

Community Health Choice, Inc.
P.O. Box 844124
Dallas, TX 75284-4124

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 policy 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 policy will be terminated. Providers will seek payment directly from you.

Deductibles/Copayments

In addition to your monthly premium payment, you are responsible for all deductibles and copayments for covered services. 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 are available online at CommunityHealthChoice.org. Upon request, we can mail you a copy. Contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org.

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

Limitations and Preferred Drug List

Community does not provide coverage for all health care expenses. Your plan does contain 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 health care 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 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 or emergency services
- Services incurred before or after coverage begins or ends
- Services not medically necessary
- Charges for prophylactic services
- Services which 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 controlled substance
- Services relating to illness or bodily 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 there from 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 Healthcare Practitioner's office
- Infertility treatment
- Reversal sterilization
- Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems
- 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
- 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 implants
- Hearing care, except as expressly provided in the Evidence of Coverage
- Charges for growth hormones (drugs, medications or hormones to stimulate growth)
- 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, counseling or services
- Services received in an emergency room, 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
- 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
- Nutritional products
- Minerals
- Herbs and vitamins
- 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
- The administration of covered medication(s)
- 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
- Compounded estrogen, progesterone, and testosterone for the treatment of hormone replacement therapy
- Infertility Treatment medications
- Any drug prescribed for impotence and/or sexual dysfunction
- Any drug, medicine or medication that is consumed or injected at the place where the prescription is given or dispensed by the healthcare practitioner or in a facility
- Injectable drugs

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.

Marketplace members requesting higher-tier drugs when a generic equivalent is available and the physician did not specifically prescribe the requested drug are responsible for the higher-tier cost-sharing amount plus any difference in cost. This cost difference does not apply to any out-of-pocket maximum.

Prior Authorization and Appeals

Prior Authorization

Prior authorization means that Community determines if the services proposed to be provided to you are medically necessary and appropriate. We require prior authorization for certain services and prescription drugs.

Prior authorization does NOT guarantee that we will cover or pay for the service, procedure or prescription drug reviewed if the healthcare practitioner, for those services, has materially misrepresented the proposed services or has substantially failed to perform the proposed services.

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 the prescription drug formulary that tells you when prior authorization is required for prescription drugs. To obtain a list, go to CommunityHealthChoice.org. Or Contact our Member Services Department at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org.

You are responsible for informing your physician or Provider of our prior authorization requirements. 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.

Please read all of the information about prior authorizations in the Evidence of Coverage. It is available online at CommunityHealthChoice.org. Upon request, we can mail you a copy. Contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org.

Appeals

An adverse determination is a determination made by Community that the health care 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. You, your Provider or someone else that you choose as your representative may also appeal. You have thirty (30) 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, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, Texas 77054
713.295.6704 or 1.855.315.5386
Fax to: 713.295.7033/Attn: Appeals Coordinator

During the Appeal Process

We will let you know we received your appeal within five (5) business 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 which 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. This will be a doctor who was not part of the original decision.

Answering your Standard Appeal

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

- Reasons for the resolution
- Clinical basis for the decision

- Types of doctors that reviewed the appeal
- Your right to a review by Texas Department of Insurance Independent Review Organization (IRO) and how to request an IRO

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 and life-threatening conditions. You can request an expedited appeal, either orally or in writing. Community will resolve your expedited appeal no later than one (1) working day from the date all of the necessary information to complete the appeal is received. Community may provide the appeal determination by telephone or electronic transmission but you will receive a letter within three (3) working days of the initial notification.

Appeal Denial – Review by an IRO

You have the right to a review of an appeal by an Independent Review Organization (IRO). If your case involves urgent or life-threatening conditions you will be entitled to an immediate appeal to an IRO without going through Community's internal appeal process. Community will send you information on how to request an IRO and the Request Form, with the appeal response letter.

Retrospective Adverse Determinations

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

You may also file a complaint with the Texas Department of Insurance:

Texas Department of Insurance
Consumer Protection Section (MC 111-1A)
P.O. Box 149091
Austin, TX 78714-9091
1.800.252.03439

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

As a Community Member, you have certain rights and responsibilities. Community is committed to ensuring that Members' rights are protected.

Members have the right to:

- Ask questions and get answers about all health care options and treatments needed for a condition
- Agree to or refuse treatment and actively participate in treatment decisions
- Get the information needed to make an informed decision
- Be treated with respect and dignity
- Make a complaint or file an appeal
- Timely access to care

Members have the responsibility to:

- Learn and understand each right they have and ask for help when they need it
- Follow all health care plan rules and policies
- Treat all doctors and health care Providers with respect and courtesy
- Inform Providers if they do not understand any type of care they are receiving or what is expected from them as part of a treatment plan. Work with their doctor, to the best of their ability, to make a treatment plan on which all can agree
- Provide the information needed to Providers, Community, and other health care contractors to get the best possible care and benefits to which you are entitled
- Inform Member Services of any changes to name, address or family Members covered under a plan

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.

Complaints

We want to help. 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 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, Inc.
Member Complaints Coordinator
2636 South Loop West, Suite 125
Houston, TX 77054

We will send you a letter within five (5) business days from the date of receipt of your complaint telling you that we received your complaint. This letter will explain the complaint process. 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 in one (1) business day of receipt of your complaint. The investigation and resolution will be concluded in accordance with the medical 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 health care services, unless another site is agreed to by you or address a written appeal to the CAP. The CAP will have equal numbers of:

- Our staff;
- Providers; and
- 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 also 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 question 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 can also complain 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 149091
Austin, TX 78714-9091
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 the Community or appealed a decision of Community.

Using Your Benefits

Benefits Information

You may obtain all Member benefit information online at CommunityHealthChoice.org. You may also contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org.

Creating a Member Account

To create a Member account:

- Go to CommunityHealthChoice.org
- Click on the Member Login
- Select "Health Insurance Marketplace" as the product
- Click "Register."
- Enter your Member Information

Your Community Care Member ID Card

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

Marketplace Member ID Card


MARKETPLACE ID CARD

COMMUNITY HEALTH CHOICE

Member Name:

Plan Name:

Member ID#:

Plan ID:

Primary Care Provider:

Effective Date:

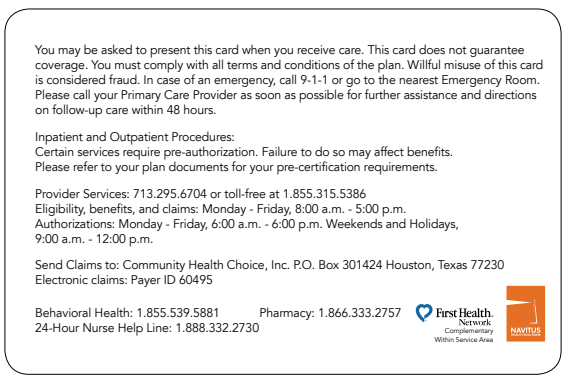
Co-Payments: PCP:
Specialist:
Pharmacy:

Urgent Care:
Emergency Room:

Deductible (Individual/Family):

Pharmacy (Navitus 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

TDI QHP


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. Willful 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

First Health Network Complementary Within Service Area

NAVITUS

Kelsey-Seybold Marketplace Member ID Card


MARKETPLACE ID CARD

COMMUNITY HEALTH CHOICE
Kelsey-Seybold Clinic

Member Name:

Plan Name:

Member ID#:

Plan ID:

Primary Care Provider:

Effective Date:

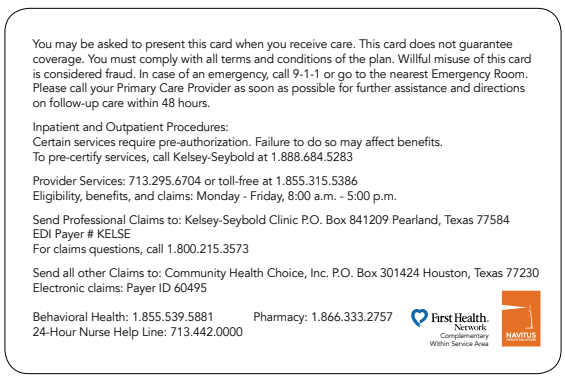
Co-Payments: PCP:
Specialist:
Pharmacy:

Urgent Care:
Emergency Room:

Deductible (Individual/Family):

Pharmacy (Navitus 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

TDI QHP


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. Willful 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-certify 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

First Health Network Complementary Within Service Area

NAVITUS

Physician Incentive Plan information

Community rewards doctors for treatments that reduce or limit services for people covered by our Marketplace Plans. This is called a Physician Incentive Plan. You have the right to know if your PCP is part of this Physician Incentive Plan. You also have a right to know how the plan works. Contact Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org to learn more about this.

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 of 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 a number of 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 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.

Limited Provider Network

A Limited Provider Network (LPN) is a group of doctors and other Providers who only refer patients to others in the same LPN. If you choose a Provider who is in an LPN to be your PCP, then your PCP will only refer you to Providers (doctors, specialists, OB/GYNs, hospitals, etc.) in the LPN.

Kelsey-Seybold is a Limited Provider Network

If you select a Kelsey-Seybold Provider as your PCP, the majority of your health services will be provided through them. Contact Kelsey-Seybold when:

- you need medical advice
- you are sick
- you need preventive care, like immunizations

When you choose a Kelsey-Seybold PCP, you are also choosing a network. Therefore, in most instances, you are not allowed to receive services from any physicians or health care professionals, including your obstetrician-gynecologist (OB/GYN), if they are not part of Kelsey-Seybold. You will not be able to select any physician or health care professional outside of Kelsey-Seybold network, even if that physician or health care provider is listed in our larger Provider Network. The Kelsey-Seybold network to which your PCP belongs will provide or arrange all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

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, contact Community Member Services for assistance at 713.295.6704 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org. You may be required to submit a copy of the itemized billing statement and a copy of your Member ID card.

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 month. Typically, if the request is received before the 15th of the month, the change is effective on the first day of the following month. If the request is received on or after the 15th of the month, the PCP change is effective on the first day of the month following the next month.

For example:

PCP change made on May 1 – May 14	PCP change effective on June 1
PCP change made on May 15 – May 31	PCP change effective on July 1

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 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 or toll-free at 1.855.315.5386 or email Marketplace@CommunityHealthChoice.org.

Our online directory clearly differentiates between Providers in Community's Network and our limited Kelsey-Seybold Provider Network. It provides an alphabetical listing of all the physicians and providers, including specialists, available in both Networks. Our online directory also provides a listing for behavioral health and substance abuse treatment Providers. Search our online directory at CommunityHealthChoice.org.

Using a Network Provider

In most instances, we have Network Providers available to provide medically-necessary services. Our Network Providers have agreed to only look to Community and not its enrollees for payment of Covered Services, except for any applicable deductible and/or copayment, as set forth in the Evidence of Coverage and summarized in your SBC. We offer other managed care plans, and a Provider who participates in one plan may not be a Network Provider for this contract. To avoid additional out-of-pocket expenses, before receiving services, ensure that the Provider is a participating Network Provider in our Marketplace plans.

Seeing a Specialist

Discuss all of 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 CommunityHealthChoice.org.

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.

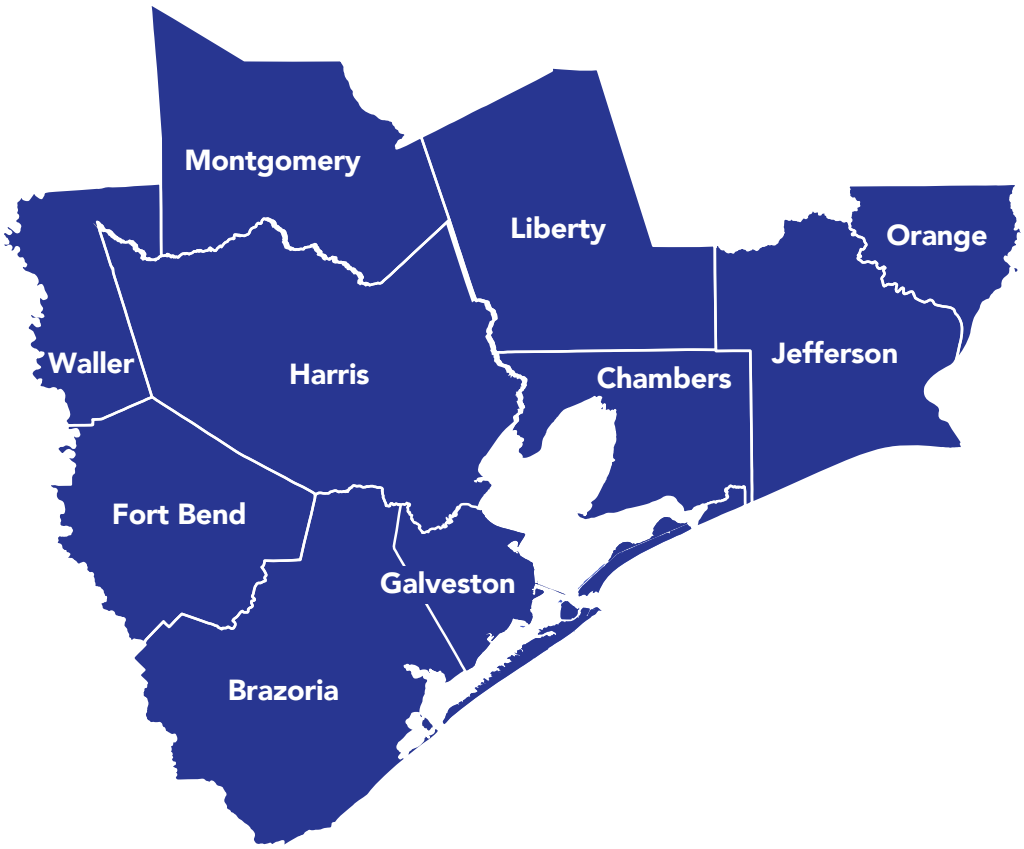
We do require prior authorization for certain services. Visit our Web site at CommunityHealthChoice.org or call the Member Services' telephone number on your Member ID card for a list of services that require prior authorization.

What does "Medically Necessary" mean?

Medically Necessary means the required extent of a healthcare service, treatment or procedure that a healthcare practitioner 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 healthcare practitioner may prescribe, authorize or direct a service does not of itself 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 healthcare practitioner;
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 Area



Fraud and Abuse

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

Community Health Choice, Inc.
Vice President of Compliance & Privacy
2636 South Loop West, Suite 125
Houston, TX 77054
1.877.888.0002

If you have access to the Internet, go to the Texas Department of Insurance (TDI) Web site at http://www.tdi.texas.gov/fraud/index.html and select the online reporting forms. If you do not have access and/or prefer to talk to a person, call the TDI Fraud Hotline toll-free at 1.800.252.3439.

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 aide in the investigation
- Dates of events
- Summary of what happened

When reporting a Client (a person who receives benefits) provide the following information available:

- The person's name
- The person's date of birth, 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 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 health care 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.
- Train employees about our privacy practices. Training is no later than sixty (60) days after their first day and at least every two (2) years after.

We have the right to change this notice. The effective date is on the bottom of each page. You can get a copy at CommunityHealthChoice.org. You can also call our Privacy Officer and ask for a copy to be mailed to you.

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 which is untrue or misleading.

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

Health Care 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 health care 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: 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 person 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.

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 health care 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 at 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 it is replaced by another Notice.

Contact Information

If you have any questions or complaints:

Community Health Choice, Inc.
Vice President of Compliance & Privacy
2636 South Loop West, Suite 125
Houston, TX 77054
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

Health Coverage Definitions

Copayment

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.

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 health care plan to enrollees on a prepaid basis.

Network

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

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 Provider
A primary care provider (PCP) is trained to manage all of your health conditions. Your PCP plays many roles: primary care giver, health care 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 health care services, prescription drugs or medical equipment require you or your Provider to obtain approval or prior authorization before to 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:

- Cardiologist
- Dermatologist
- Surgeon

Step Therapy
A type of Prior Authorization required for some high-cost drugs.

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:

- 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 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 Marketplace@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 by check or credit card by phone. All future payments can made by check, credit card by telephone, electronic payment via member portal or as a walk-in payment at an approved vendor. For a list of approved vendors, visit the Community Web site.

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. Note that cancellation of your coverage may result in you owing a federal tax penalty.

Can I change plans at any time?
Plans can only be changed during open enrollment, unless you have a qualifying event.

How can I check claim status?
You can check claims status by logging into your Community Member account or by contacting Community Member Services at 713.295.6704 or toll-free at 1.855.315.5386 or email at Marketplace@CommunityHealthChoice.org.

How do I select Kelsey-Seybold as my Provider?
ONLY Members enrolled in Community's Copay Plans are eligible to select Kelsey-Seybold as their PCP and utilize their services. Copay plan Members are able to change their PCP selections on a monthly basis. However, it is important to note that changes in PCP selection are not immediate. Contact Member Services for further details on the effective dates for PCP changes.

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.