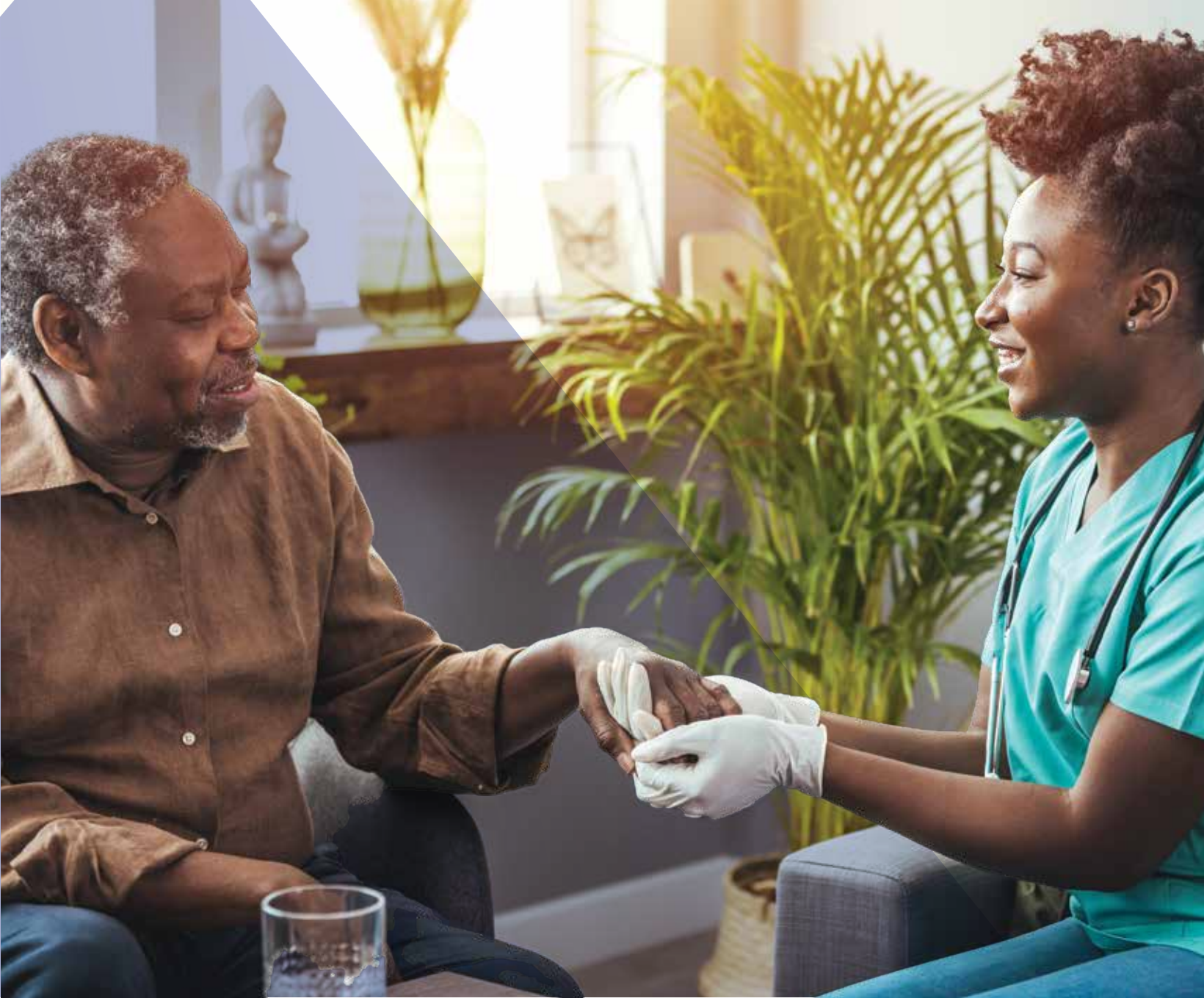


STAR+PLUS NURSING FACILITY SEPTEMBER 2024

MEMBER HANDBOOK

www.CommunityHealthChoice.org
713.295.2300
1.888.435.2850

Community Health Choice Texas, Inc. is an affiliate of the Harris Health System.

TEXAS Health and Human Services | TEXAS STAR+PLUS Your Health Plan ★ Your Choice

COMMUNITY HEALTH CHOICE

SPHB_NURSE_42024

INTRODUCTION

Welcome to Community Health Choice

We are excited to serve you! Community Health Choice is a local, non-profit, Managed Care Organization (MCO) with a mission to improve the health and well-being of Texas residents throughout Harris county.

As a Community Health Choice Member, we want to make sure that you have access to information and services you need to get started.

Here are a few reminders:

- If you have special needs, have trouble seeing or speak another language, please call our Member Services Department toll-free at 1.888.435.2850.
- We will send you this information in a way that you can read it. If you need an interpreter to help you understand this handbook, we can provide you oral or written interpreter help. If you need help with sign language, Community offers Sign Share. If you have trouble hearing or speaking, please call the TTY/TDD line at 7-1-1 or toll-free at 1.800.735.2989.
- If you need auxiliary aids and services, including getting materials in alternative formats like large print or Braille, please call the HHSC Eligibility Office toll-free at 1.855.827.3748 or our Member Services Department toll-free at 1.888.435.2850.

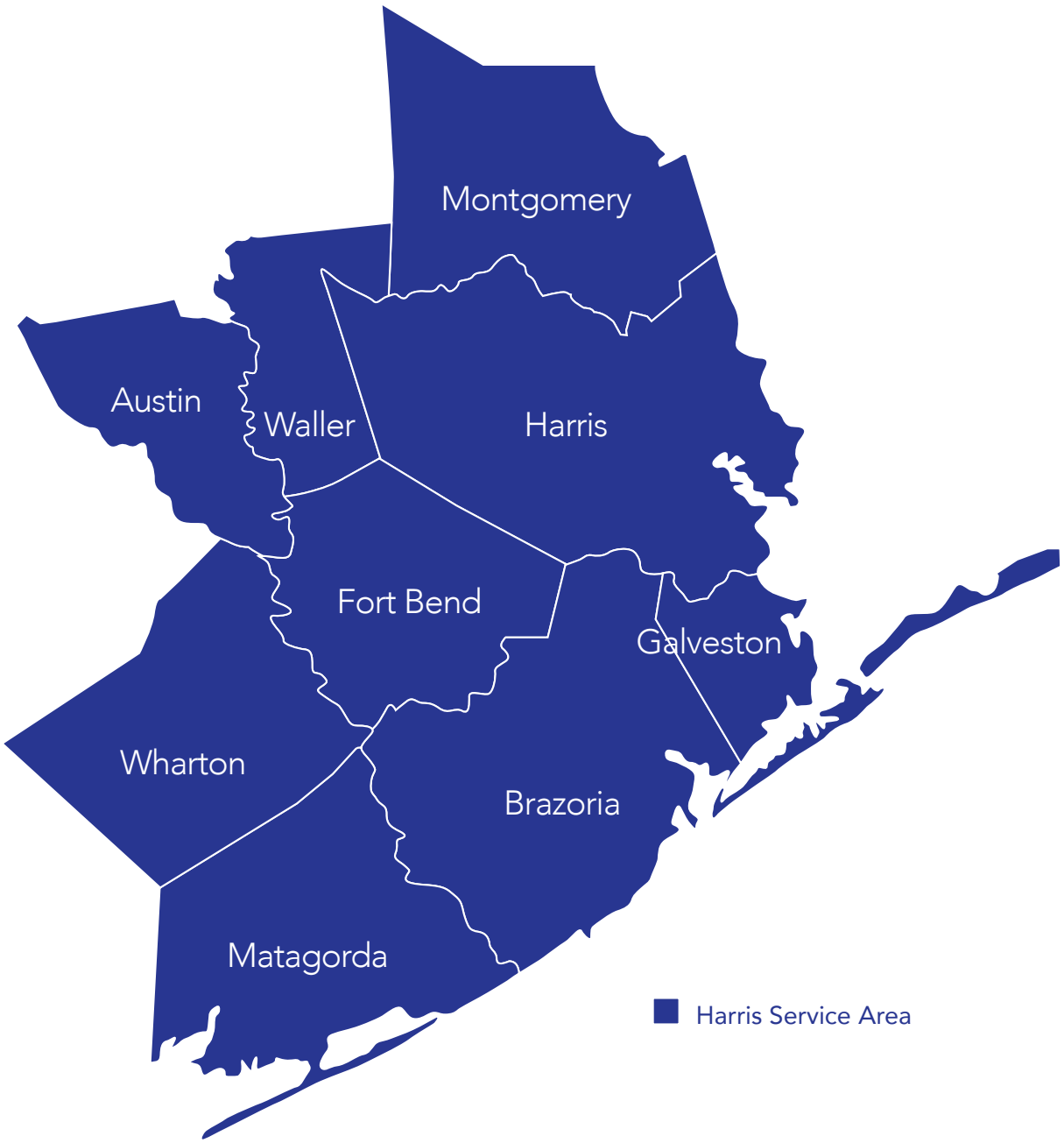
Community is committed to assisting our Members. We provide 24-hour access through toll-free phone numbers to connect directly to our Member hotline, Behavioral Health (BH) Non-Crisis hotline, BH Crisis hotline, Service Coordination hotline and the Non-Emergency Medical Transportation (NEMT) services hotline.

To reach our Member Service staff call 8:00 a.m. - 5:00 p.m., Monday – Friday, excluding state-approved holidays. Access your My Member Account online 24 hours a day, seven days a week.

IMPORTANT PHONE NUMBERS

1.888.435.2850 713.295.2300	**Member Services** 24 hours a day, 7 days a week, excluding state-approved holidays. Access your Member account online 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. Also call for pharmacy and dental information.
1.888.435.5150 713.295.5004	**Service Coordination** Service Coordination Team is available 8:00 am - 5:00 pm Monday- Friday, excluding state approved holidays. After business hours you can leave a message and calls will be returned within one business day or call Member Services hotline at 1.888.435.2850. In case of an emergency, call 9-1-1 or go to the nearest hospital. If you have trouble hearing or speaking, please call the TTY line at 7-1-1.
1.866.566.8989	**Ombudsman Managed Care Assistance Team (OMCAT)**
1.877.343.3108	**Behavioral Health/Substance Abuse Services and Crisis Hotline** **Community Health Choice** Crisis Hotline: 24 hours a day, 7 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.
7-1-1 1.800.735.2989	**TTY for Hearing-Impaired:** Member Services Ombudsman Managed Care Assistance Team (OMCAT) TTY 711
1.800.206.9052	**24-Hour Nurse Advice Line**
1.800.264.2777	**STAR+PLUS Program Helpline**
1.844.572.8194	**STAR+PLUS Non-Emergency Medical Transportation (NEMT) – Access2Care** Call to schedule and to check the status of your ride. Access2Care is available 24 hours a day, 7 days a week. Call Access2Care toll-free at 1.844.572.8194 or schedule through the Access2Care (A2C) Member app. Download the app from your app store. Information is available in English and Spanish. Call Access2Care to get an interpreter. 7-1-1 TTY for Hearing-Impaired. In case of an emergency, call 9-1-1 or go to the nearest hospital.
1.877.847.8377	**Texas Health Steps Program**
1.844.686.4358	**Vision Services** Envolve Vision visionbenefits.envolvehealth.com
1.877.727.9570	**Dental Services** FCL Dental
1.800.822.5353 1.888.760.2600	**Pharmacy** Community Health Choice Member Services 8:00 a.m. – 5:00 p.m., Monday – Friday, excluding state-approved holidays.

Service Area Map



Contents

Member Identification (ID) Card

Information about the Member Identification (ID) Card

Every eligible Member of your family will get their own Member ID Card. Carry your Member ID Card and Your Texas Benefits Medicaid Card with you at all times. Show both to your doctor or healthcare Provider before you get care. You will get your Member ID card within 3–5 business days of your enrollment date.

How to Read your Member ID Card

Check your Member ID Card to make sure it is correct. It should have:

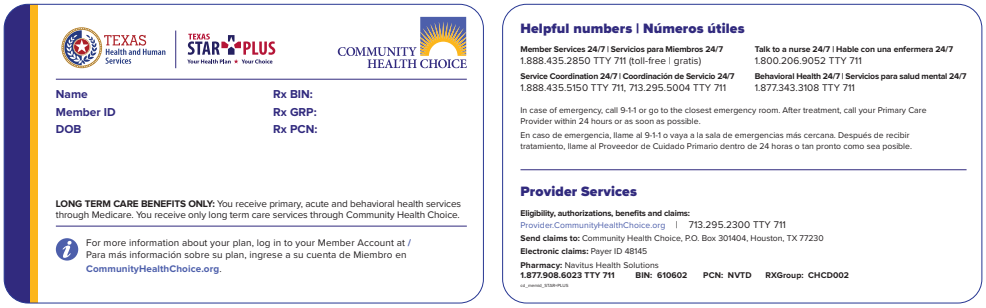
- Your name
- Your Medicaid Number
- Your Primary Care Provider's name, address, and telephone number, so you can schedule an appointment or discuss your healthcare needs.

How to Use your Member ID Card

Here is a sample of our Member ID Card:

MEMBERS WITH MEDICAID (STAR+PLUS) ONLY- MEMBER ID CARD

MEMBERS WITH MEDICAID (STAR+PLUS) AND MEDICARE- MEMBER ID CARD



If you have both Medicare and Medicaid, your Community Health Choice Member ID card will not show a doctor's name of phone number. Your ID card will show as the above example.

It is important that you:

- Have your Member ID Card and Medicaid number ready when you call Member Services toll-free at 1.888.435.2850 TTY 711.
- Bring your Member ID Card and Your Texas Benefits Medicaid Card to all medical appointments.
- Do not let other people use your Member ID Card.

How to Replace your Member ID Card

Print a temporary ID Card through your My Member Account at www.CommunityHealthChoice.org > Member Login. Member Services will mail you a permanent one. Or call toll-free at1.888.435.2850 TTY 711.

Your Texas Benefits (YTB) Medicaid Card

When you are approved for Medicaid, you will get a YTB Medicaid card. This plastic card will be your everyday Medicaid card. You should carry and protect it just like your driver's license or a credit card. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will be issued only one card, and you will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free 1.800.252.8263, or by going online to order or print a temporary card at www.YourTexasBenefits.com.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1.800.252.8263. You can also call 2-1-1. First pick a language and then pick option 2.

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your medical and dental information through the secure online network, call toll-free at 1.800.252.8263 or opt out of sharing your health information at www.YourTexas Benefits.com.

The YTB Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the program you're in if you get:
  - Medicare (QMB, MQMB)
  - Healthy Texas Women Program (HTW)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE).
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the Your Texas Benefits Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call toll-free (1.800.252.8263) if you have questions about the new card.

If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

The YourTexasBenefits.com Medicaid Client Portal

The Medicaid Client Portal lets you do all of the following for anyone who is part of your case:

- View, print, and order a Your Texas Benefits Medicaid card
- See your medical and dental plans
- See your benefit information
- See Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

To access the portal, go to www.YourTexasBenefits.com.

- Click Log In.
- Enter your User name and Password. If you don't have an account, click Create a new account.
- Click Manage.
- Go to the "Quick links" section.
- Click Medicaid & CHIP Services.
- Click View services and available health information.

NOTE: The YourTexasBenefits.com Medicaid Client Portal displays information for active clients only. Legally Authorized Representatives can view anyone who is a part of their case.

- Information about temporary verification form - Form 1027-A (how to use it).
  - – Emergency Medicaid, or
  - – Presumptive Eligibility for Pregnant Women (PE)

Temporary Medicaid ID Verification Form 1027-A

If you lose the Your Texas Benefits Medicaid Card, call your local HHSC Eligibility Office toll-free at 1.800.964.2777. They will give you a Medicaid Temporary ID Verification Form 1027-A. You will use the Form 1027-A as proof of your Medicaid eligibility. The form will have a "through" date. This is the last day this form can be used. It will also list each family Member who is part of your Medicaid case. You must take your Form 1027-A with you when you get any healthcare services. Use it like Your Texas Benefits Card and present to your Provider.

What does the Medicaid card look like?

The card is plastic, like a credit card, and it has your name and Medicaid ID number on the front.

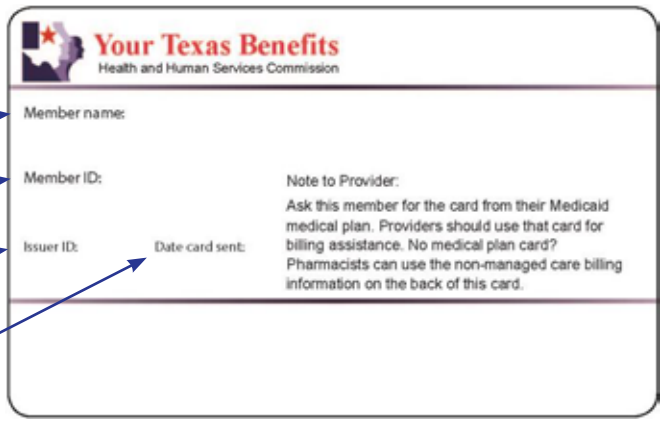
Front of the card:

This is where your name appears.

This is your Medicaid ID number.

This is HHSC's agency ID number.
Doctors and other providers need this number.

This is the date the card was sent to you.



Back of the card:

This message is for you.

This reminds your doctor to make sure you are still in the Medicaid program before giving you services.

These messages help doctors and providers get paid for the Medicaid services they give you.

Primary Care Providers

What is a Primary Care Provider?

Your Primary Care Provider is an important part of your healthcare team. Your Primary Care Provider will make sure you get the care you need such as give you regular checkups and treat you when you are sick. Your Primary Care Provider will follow up when other doctors give you care. Your Primary Care Provider should be the "medical home" of all your medical records. Your Primary Care Provider needs to know everything about your past and present healthcare needs. Make sure your Primary Care Provider has all of your medical records. If you are a new patient, help your Primary Care Provider 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 Primary Care Provider.

You can pick any Primary Care Provider in the Community Health Choice network. You should pick a Primary Care Provider with an office location and office hours that are convenient for you. If you like the Primary Care Provider that you see now, you can continue to see them if they are listed in our directory.

Once you pick your Primary Care Provider, please call Member Services toll-free at 1.888.435.2850 TTY 711 we will assign your selected Primary Care Provider.

For a current directory, go to www.CommunityHealthChoice.org > Find a Doctor > Medicaid/STAR+PLUS > Find a Provider > Enter your information > Search. You can find a doctor By Provider's Specialty, By Provider's Name or By Provider's County.

It is important that you get to know your Primary Care Provider, and your Primary Care Provider gets to know you. It is not good to wait until you are sick to pick and meet your Primary Care Provider.

As a new Member, you should have your first checkup within 90 calendar days after joining Community Health Choice.

We can help you schedule your first checkup and get transportation to your Provider's office. Call Access2Care toll-free at 1.844.572.8194 or schedule through the Access2Care (A2C) Member app. Download the app from your app store.

Will I be assigned a Primary Care Provider if I have Medicare?

For STAR+PLUS Members who are covered by Medicare, no Primary Care Provider will be assigned.

How do I see my Primary Care Provider if s/he does not visit my nursing home?

If you need to leave the Nursing Facility for a doctor visit, the Nursing Facility will provide transportation.

How can I change my Primary Care Provider?

You can change your Primary Care Provider by:

- Calling us toll-free at 1.888.435.2850 TTY 711
- Creating a My Member Account and changing it online at www.CommunityHealthChoice.org
- Writing us at:

Community Health Choice Texas, Inc.
Attention: Member Services
4888 Loop Central Drive, Suite 600,
Houston, TX. 77081

When will my Primary Care Provider change become effective?

When you call us to change your Primary Care Provider, we will make the change in our computer system while you are on the phone. The effective date of the change will be the first of the next month. We will also send you a new Member ID Card right away.

What is the Medicaid Lock-in Program?

You may be placed in the Lock-in Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different Community Health Choice will not change the Lock-In status.

To avoid being placed in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more call Community Health Choice.

Physician Incentive Plan Information

Community Health Choice rewards doctors for treatments that are cost-effective for people covered by Medicaid.
You have the right to know if your primary care provider (main doctor) is part of this physician incentive plan. You also have a right to know how the plan works. You can call 1.888.435.2850 TTY 711 to learn more about this.

Changing Health Plans

What if I want to change health plans?

You can change your health plan by calling the STAR+PLUS Program Helpline at 1.800.964.2777. You can change health plans as often as you want, but not more than once a month.

If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged.

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Who do I call?

Call the Texas STAR or STAR+PLUS Program Helpline at 1.800.964.2777.

How many times can I change health plans?

You can change health plans as often as you want.

When will my health plan change become effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that.

For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can Community Health Choice ask that I get dropped from their health plan (for non-compliance, etc.)?

Yes. Community Health Choice can request that you be disenrolled if you:

- Move out of our service area
- Enter a hospice or long-term care facility
- Are not eligible for Medicaid
- Enroll in another plan

We might also request HHSC to end your Membership after letting you know if you:

- Miss three appointments in a row over six months and do not call to cancel;
- Do not follow Community Health Choice policies and procedures;
- Allow your Member ID Card to be misused; or
- Are disruptive, abusive or do not cooperate with Community Health Choice staff, doctors or other Providers.

Benefits

What are my health care benefits?

Community Health Choice is one of the Texas STAR+PLUS plans and provides services that are covered benefits of the Medicaid Program. Some of the covered benefits include:

1. Emergency and non-emergency ambulance services;
2. Audiology services, including hearing aids, for adults and children;
3. BH Services, including: a. Inpatient mental health services for adults and children. Inpatient psychiatric hospital services provided in a free-standing psychiatric hospital to Members under age 21 or ages 65 and older are not subject to a day limitation for services; b. MHR and Mental Health TCM for individuals who are not dually enrolled in Medicare and Medicaid outpatient mental health services for adults and children; c. Psychiatry services; d. Counseling services for adults (21 years of age and over); e. SUD treatment services, including: i. Outpatient services, including: (1) Assessment; (2) Withdrawal management services; (3) Counseling (individual and group); and (4) MAT; ii. Residential services, which may be provided in a CDTF in lieu of an Acute Care inpatient Hospital setting, including: (1) Residential withdrawal management; and (2) Residential treatment (including room and board)
4. Prenatal care provided by a physician, Certified Nurse Midwife (CNM), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and physician assistant in a licensed birthing center;
5. Birthing services provided by a physician and CNM in a licensed birthing center;
6. Birthing services provided by a licensed birthing center;
7. Cancer screening, diagnostic, and treatment service;
8. Chiropractic services;
9. CFC services, including:
   a. PAS;
   b. Habilitation;
   c. Emergency response services; and
   d. Support consultation;
10. Day Activity and Health Services (DAHS);
11. Dialysis;
12. DME and supplies;
13. Emergency Services;
14. Family planning services;
15. Home health care services provided in accordance with 42 C.F.R. § 440.70, and as directed by HHSC;
16. Hospital services, inpatient, and outpatient;
17. Laboratory;
18. Mastectomy, breast reconstruction, and related follow-up procedures, including:
    a. Outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
        i. All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
        ii. Surgery and reconstruction on the other breast to produce symmetrical appearance;
        iii. Treatment of physical complications from the mastectomy and treatment of lymphedemas; iv. Prophylactic mastectomy to prevent the development of breast cancer; and v. External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
19. Medical checkups and CCP services for Members under 21 years of age through the THSteps Program;
20. NEMT Services, including: a. Demand response transportation services, including NMT prearranged rides, shared rides, and public transportation services; b. Mass transit; c. Individual Transportation Participant (ITP) mileage reimbursement; d. Meals; e. Lodging; f. Advanced funds; and g. Commercial airline transportation services, including out of state travel;

21. NF Services;
22. Oral evaluation and fluoride varnish in the Medical Home in conjunction with THSteps medical checkup for Members under 21 years of age;
23. Outpatient drugs and biologicals, including pharmacy-dispensed and provider administered outpatient drugs and biologicals, and drugs and biologicals provided in an inpatient setting;
24. PCS for Members under 21 years of age;
25. Podiatry;
26. Prenatal care;
27. PPECC services for Members under 21 years of age;
28. Preventive services including an annual adult well check for patients 21 years of age and over;
29. Primary care services;
30. PDN services for Members under 21 years of age;
31. Radiology, imaging, and X-rays;
32. Specialty physician services;
33. Specialty Therapies – physical, occupational and speech therapies;
34. Transplantation of organs and tissues;
35. Vision services, including optometry and glasses. (Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.);
36. Telemedicine;
37. Telemonitoring, to the extent covered by Tex. Gov't Code § 531.0216; and
38. Telehealth.

Adult Members receive three enhanced benefits compared to FFS coverage:

1. Waiver of the three-prescription per month limit, for Members not covered by Medicare;
2. Waiver of the $200,000 individual annual limit on inpatient services; and
3. The 30-day spell of illness limitation for hospital inpatient services described in the State plan does not apply to STAR+PLUS Members with SPMI.
4. STAR+PLUS HCB PAS
5. Nursing services (in-home);
6. Emergency response services (emergency call button);
7. Home delivered meals;
8. Dental services;
9. Respite care, including in-home or out-of-home respite;
10. Minor Home Modifications;
11. Adaptive Aids and medical supplies;
12. Specialty Therapies;
13. Adult foster care;
14. Assisted living;
15. Transition Assistance Services (TAS);
16. Cognitive rehabilitation therapy;

17. FMS;
18. Support consultation;
19. Employment assistance;
    a. Members receiving similar services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act may not receive Employment Assistance through STAR+PLUS HCBS.
20. Supported employment;

How do I get these services?

Please look online at www.CommunityHealthChoice.org > Find a Doctor to find a Provider in your area to give you these services.

Are there any limits to any covered services?

We provide medically necessary services that are covered by the Medicaid Program. If the Medicaid Program does not cover the service, then we do not cover the service.

What are Long-Term Services and Supports (LTSS)?

Long Term Care services and Supports are benefits that help you stay safe and independent in your home or community. You can get Long Term Care services if you need help with daily healthcare and living needs. Some of the services include helping you dress, bathe, or go to the bathroom; preparing meals; doing light housework; or helping with your grocery shopping.

Community First Choice (CFC)

What is Community First Choice (CFC)? Who is eligible for CFC Services?

Community First Choice benefits provide home and community-based supports and services to certain Medicaid members with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. Members who need an institutional level of care (example: hospital, nursing facility, intermediate care facility, etc.) and who need help or want to become more independent may be eligible for CFC Services. Members living in a community-based home may be able to get these services. Call Member Services for more eligibility information.

What CFC services are available?

CFC provides services such as:

- Personal assistance services (PAS): help with daily living activities and health-related tasks
- Habilitation Services: services to help members learn new skills and care for themselves
- Emergency Response Services: help if members live alone or are alone for most of the day
- Support Management: training on how to select, manage and dismiss attendants

If you think you need CFC services, your Service Coordinator will be able to help schedule an assessment. If you have questions about CFC services and/or eligibility, call your Service Coordinator or Member Services.

What are my Nursing Facility LTSS benefits?

Long Term Care services and Supports are benefits that help you stay safe and independent in your home or community. You can get Long Term Care services if you need help with daily healthcare and living needs. Some of the services include helping you dress, bathe, or go to the bathroom; preparing meals; doing light housework; or helping with your grocery shopping.

Other STAR+PLUS, Long Term Care and Support (LTSS) Benefits?

Some STAR+PLUS members can get other long term care services that are based on their medical need These are called STAR+PLUS Waiver Services (you may have heard of these services called CBA):

- Adaptive aids such as: wheelchairs, walkers, canes, and durable medical equipment
- Adult Foster Care
- Assisted Living Services
- Consumer Directed Servcies
- Emergency Response Services
- Home Delivered Meals
- Minor Home Modifications
- Nursing Facility Services
- Personal Care Attendant
- Respite Care Services
- Therapy Services (physical, occupational, speech)
- Protective Supervision
- Transition Assistance Services
- Dental Services
- Cognitive Rehabilitation Therapy

How would my benefits change if I moved into the community?

Your STAR+PLUS benefits will not change if you move into the community. For more information, call Member Services at 1.888.435.2850.

What are my Acute Care benefits?

Acute care benefits include services like doctor visits, x-rays, labs, and other medical benefits. For more information on acute care benefits call your Service Coordinator or Member Services at 1.888.435.2850 TTY 711. Please remember that if you have Medicare and Medicaid your acute care benefits are covered by Medicare.

How do I get these services?

Please look online at www.CommunityHealthChoice.org > Find a Doctor to find a Provider in your area to give you these services.

What number do I call to find out about these services?

Call your Service Coordinator or Member Services at 1.888.435.2850 TTY 711.

What services can I still get through regular Medicaid but are not covered by Community Health Choice)?

- Preadmission Screening and Resident Review PASRR - PASRR is a federal requirement to help determine whether an individual is not inappropriately placed in a nursing home for long term care.
- Hospice

What are my prescription drug benefits?

Non-Duals Only

Prescription drugs are covered when:

- The drug is on the Texas Vendor Drug Formulary
- The prescription is filled at a network pharmacy
- They are ordered by your PCP or another doctor treating you or your child.

You can look for the Guide to Accessing Quality Healthcare, located on the Quality Improvement Program section of our website, CommunityHealthChoice.org, or call Member Services if you want to know more about your drug benefits and the pharmacy process.

What extra benefits do I get as a Member of Community Health Choice?

Value-Added Services are effective September 1, 2023 to August 31, 2024. Limitations may apply. If you have any questions, call Member Services toll-free at1.888.435.2850 TTY 711.

24-Hour Advice Hotline

Nurse Help Line available 24 hours a day, 7 days a week. Nurses provide education, nurse-initiated follow-up and network referrals.

Dental Services

Two routine dental exams per year, up to $600 with teeth cleaning, x-rays (once-annually), non-surgical extractions and emergency exams (limited) for Members 21 and older.

Extra Vision Services

Members may opt-out of standard eye wear benefit and use $150 towards purchase of non-standard glasses or contacts, including contact fitting fee, every 24 months.

Temporary Phone Help

Members ages 21 and older who qualify for the federal lifeline program can get a free cell phone with talk and text and unlimited data through the federal lifeline program.

Health and Wellness Services

Access to online resources, to connect with free or low-cost community resources. Free blanket for newly enrolled members. Free digital, large print clock for newly enrolled members. Free pair of non-skid socks.

Healthy Play and Exercise

Exercise kit, which may include a resistance band, hand weight and pedometer for members.

Gift Programs

$85 gift card for diabetic members who get an HbA1c blood test every 6 months. $30 gift card for diabetic members who get a diabetic eye exam each year. $30 gift card for members with schizophrenia or bipolar disorder who are using antipsychotic medications and received a diabetic screening. $30 gift card each year for current female members who get a recommended mammogram.

Online Mental Health Resources

Online telehealth resources and mental health online companionship tool.

How can I get these benefits?

Call Member Services at 713.295.2300 or toll-free at 1.888.435.2850 TTY 711.

What health education classes does Community Health Choice offer?

The goal of our Health Education Program is to help our Members learn to stay healthy. Our Health Education Program offers health fairs and wellness screenings.

Complex Case Management Program

Community's Complex Case Management Program helps coordinate care for Members who have complex medical conditions. Our Complex Case Managers help our Members with health care and other community services as needed. These services and the Complex Case Management Program are free to all members and all information obtained is confidential. Our Complex Case Managers will speak with you and assess your healthcare needs as well as your social determinants of health.

Areas of assistance includes the following:

- Education about your medical condition
- Help obtaining medical supplies or equipment
- Developing a plan with you and your primary care provider to meet your medical needs
- Help with finding community resources such as transportation, housing, food, child care, and personal care services

You may contact a Complex Case Manager Monday to Friday, 8:00 a.m.–5:00 p.m. by calling Community Health Choice at 832.242.2273.

Care Management Program

Our Care Management Program helps you manage your healthcare needs. We focus on Asthma, Diabetes, Heart Failure, End-Stage Renal Disease (ESRD), Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Obesity, High-risk pregnancy, and Members with complex medical conditions.

We will contact you if you:

- Meet the criteria for any of the programs we offer at Community Health Choice
- Are at risk for having your baby early we will help you:
- Get care after your baby is born
- Manage your healthcare needs
- Coordinate your care

Call our Care Management Department at 832.CHC.CARE (832.242.2273) or toll-free at 1.888.297.4450. Take charge of your health! Take our Health Risk Assessment online to see if you have any potential health issues. Go to www.CommunityHealthChoice.org > Member Resources. We will review it and contact you if we see any potential issues. Share your results with your doctor.

Health Care and Other Services

What does Medically Necessary mean?

Both Acute Care and Behavioral Health

Medically Necessary means:

(1) For Members age 21 and over, non-behavioral health related health care services that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;

(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;

(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(d) consistent with the diagnoses of the conditions;

(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(f) not experimental or investigative; and

(g) not primarily for the convenience of the Member or provider; and

(2) For Members age 21 and over, behavioral health services that:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level or supply of service that can safely be provided;

(e) could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or provider.

Community Health Choice will determine medical necessity for Nursing Facility Add-on Services and Acute Care Services only. Nursing Facility Add-on Services include, but are not limited to emergency dental services, physician-ordered rehabilitative services, customized power wheelchairs, and audio communication devices.

What is routine medical care?

Routine medical care is when you visit your Primary Care Provider to make sure you are in good health. Routine medical care includes regular checkups, treatment for illnesses, immunizations, and follow-up care.

How soon can I expect to be seen?

You should be able to see your Primary Care Provider within two weeks of your call to the Provider.

Are non-emergency dental services covered?

Community Health Choice is not responsible for paying for routine dental services provided to Medicaid Members.

Community Health Choice is responsible, however, for paying for treatment and devices for craniofacial anomalies.

What is emergency medical care?

Emergency Medical Care

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

Emergency Medical Condition means:

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Emergency Behavioral Health Condition means:

Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson, possessing average knowledge of medicine and health:

1. requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
2. which renders the Member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency Services and Emergency Care means:

Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post-stabilization care services.

How soon can I expect to be seen?

Emergency wait time will be based on your medical needs and determined by the emergency facility that is treating you. You should be seen immediately for emergency, medical or behavioral health services.

Do I need a prior authorization?

You do not need prior authorization from your Primary Care Provider for emergency care services.

Are Emergency Dental Services Covered?

Community Health Choice covers limited emergency dental services for the following:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Drugs for any of the above conditions.

Community Health Choice is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs).

Covered emergency dental procedures include, but are not limited to:

- alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- open or closed reduction of fracture of the maxilla or mandible;
- repair of laceration in or around oral cavity;

- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- incision and drainage of cellulitis;
- root canal therapy. Payment is subject to dental necessity review and pre- and post- operative x-rays are required; and
- extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

What is post stabilization?

Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

What if I get sick when I am out of the facility/or traveling out of town?

If you need medical care when traveling, call us toll-free at 1.888.435.2850 TTY 711 and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1.888.435.2850 TTY 711.

What if I am out of the state?

If you have an emergency while you are out-of-state, go to the nearest emergency room for care. If you get sick and need medical care while you are out-of-state, call you Primary Care Provider. Your Primary Care Provider can tell you what you need to do if you are not feeling well.

What if I am out of the country?

Medical services performed out of the country are not covered by Medicaid.

What if I need to see a special doctor (specialist)?

Your Primary Care Provider can treat most problems. Your PCP might want you to see a special doctor (specialist) for certain health care needs. While your PCP can take care of most of your health care needs, sometimes they will want you to see a specialist for your care. A specialist has received training and has more experience taking care of certain diseases, illnesses and injuries. Community Health Choice has many specialists who will work with you and your PCP to take care of your needs.

What is a referral?

A referral happens when your doctor talks to you about your needs and helps make plans for you to see a specialist that can provide the best care for you. Your doctor is the only one that can give you a referral to see a specialist. If you have a visit, or receive services from a specialist without your PCP's referral, or if the specialist is not in Community Health Choice's provider network, you might be responsible for the bill. In some cases, an OB/GYN can also give you a referral for related services.

How soon can I expect to be seen by a specialist?

Sometimes, the specialist may see you right away. Depending on the medical need, it may take up to a few weeks after you make the appointment to see the specialist.

What services do not need a referral?

A referral is not needed for:

- Emergency Services
- Behavioral Health Services
- Routine Vision Services
- Routine Dental Services
- OB/GYN care

How can I ask for a second opinion?

Please call Member Services if you want a second opinion. You can get a second opinion from a network Provider or an out-of-network Provider if a network Provider is not available. You may want to ask for a second opinion if:

1. You received a diagnosis or instructions from your Provider that you don't feel are correct or complete.
2. Your Provider says you need surgery.
3. You have done what the doctor asked, but you are not getting better. When you go for your visit, tell the doctor you are there for a second opinion.

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

Community Health Plan covers medically necessary Substance Abuse and Behavioral Health Care services. If you have a drug problem or are very upset about something, you can get help. You can call Member Services at 1.888.435.2850 for help. You do not need a referral for these services. There will be people who can speak with you in English or Spanish. If you need help with other languages, please tell them. Member Services will connect you to the Language Line and answer your questions. Please call TTY: 7-1-1, for deaf and hard of hearing.

In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.

Do I need a referral?

You do not need to see your Primary Care Provider first or get a referral from your Primary Care Provider. Some mental health or substance abuse problems may also need urgent care.

For help with these problems or for more information, please call Community Health Choice. Call toll-free at 1.888.435.2850 TTY 711, 24 hours a day, 7 days a week.

Community Health Choice follows the Mental Health Parity and Addiction Equity Act (MHPAEA). We review to make sure that requirements for mental health benefits are the same and not more restrictive than medical benefits.

What are mental health rehabilitation services and mental health targeted case management?

Mental Health Rehabilitative Services is a community-based program. These services are provided to people with mental health disorders. You will learn new skills. These new skills build on your strengths and abilities. These new skills will help you during a crisis. Your mental health provider will assess your need for these services. These services can be provided with other mental health services. Mental Health Targeted Case Management is a community-based program. These services are provided to people with mental health disorders.

How do I get these services?

You can get these special services at your Local Mental Health Authority or Mental Health and Mental Retardation Association (MHMRA). There are special requirements for these services.

How do I get my medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription and send the prescription for you by calling, faxing or submitting by electronic means to the nursing facility to order, fill, dispense and administer to you.

What if I also have Medicare?

Medicare or your Medicare Health Plan will pay for your services before Community Health Choice will. Community Health Choice may cover some services that are not covered by Medicare for STAR+PLUS members. Prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D.

What if I go to a drug store not in the network?

We have a lot of drug stores in our network. Please look on our Web site at www.CommunityHealthChoice.org > Find a Doctor > Products > Find a Pharmacy for a complete list. You can also call Member Services at 713.295.2300 or toll-free at 1.888.435.2850 TTY 711 for help. If you do go to a drug store that is not in our network, your prescription will not be covered by us, and you will have to pay full price.

What do I bring with me to the drug store?

If you go to the drugstore, you should bring:

- Your prescription(s) or medicine bottles.
- Your Community Health Choice ID card or your Medicare plan ID card.
- Your Texas Benefits Medicaid card.

What if I need my medications delivered to me?

Some pharmacies in our network will deliver to your home. Please look on our Web site at www.CommunityHealthChoice.org > Find a Doctor > Find a Pharmacy to see which ones will deliver. You can also call Member Services toll-free at 1.888.435.2850 TTY 711 for help.

Who do I call if I have problems getting my medications?

Community Health Choice will work with you, the nursing facility, and the pharmacy to make sure you get the medicine you need. If you are having problems getting your medications, please call us at 1.888.435.2850 (711) or call TTY: 7-1-1 for deaf and hard of hearing.

What if I can't get the medication my doctor ordered approved?

If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication.

Call Community Health Choice at 1.888.435.2850 TTY 711 for help with your medications and refills.

What if I lose my medication(s)?

If your medicine is lost or stolen, have your nursing facility call Member Services toll-free at 1.888.435.2850 TTY 711 for instructions on what you need to do.

How do I get family planning services?

Do I need a referral for this?

You do not need a referral. You can find the locations of family planning Providers near you online at Healthy Texas Women: https://www.healthytexaswomen.org/ or you can call Community Health Choice toll-free at 1.888.435.2850 TTY 711 for help in finding a family planning provider.

Where do I find a family planning services provider?

You can find the locations of family planning providers near you online at http://www.dshs.texas.gov/famplan, or you can call Community Health Choice at 1.888.435.2850 TTY 711 for help in finding a family planning provider.

What is Service Coordination?

Specialized services/care process that includes, but is not limited to:

- Identifying the physical, mental or long term needs of the Member
- Addressing any unique needs of the Member that could improve outcomes & health/well-being

- Assisting the Member to ensure timely & coordinated access to array of services and/or covered Medicaid eligible services
- Partner with nursing facility to ensure best possible outcomes for the Member's health & safety
- Coordinate the delivery of services for Members who are transitioning back to the community

What will a Service Coordinator do for me?

Service Coordination is a service Community Health Choice gives you to help with your health and well-being. A Service Coordinator will review, plan and help you in meeting your health care needs. Your Service Coordinator can help you:

- Arrange care with your Primary Care Provider
- Help with any medical, behavioral health and Long-Term Services and Supports
- Solve any problems with your medical care or providers
- Find ways for you to live at home or in other community settings
- Explain service and placement choices to you
- Encourage you to take part in your care

How can I talk with a Service Coordinator?

To contact your Service Coordinator, call Member Services at 1.888.435.2850. Call TTY: 7-1-1 for deaf and hard of hearing.

What transportation services does the Community Health Choice provide?

Community Health Choice TRANSPORTATION SERVICES FOR NURSING FACILITY RESIDENTS

What transportation services are offered?

The Nursing Facility is responsible for providing routine non-emergency transportation services. If medically necessary, Community Health Choice provides non-emergency ambulance transportation for Members that require this service.

How do I get this service?

To get non-emergency ambulance transportation, your provider must contact Community Health Choice to request authorization for these services.

What services are offered?

To get non-emergency ambulance transportation, your provider must contact Community Health Choice to request authorization for these services.

Who do I call for a ride to a medical appointment?

Call Access2Care toll-free at 1.844.572.8194 or schedule through the Access2Care (A2C) Member app. Download the app from your app store.

You should request Access2Care Services as early as possible, and at least two business days before you need the Access2Care service. In certain circumstances, you may request the Access2Care service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

You must notify Access2Care prior to the approved and scheduled trip if your medical appointment is cancelled

How do I get eye care services?

Call the vision provider listed on page 3, "Important Phone Numbers."

Can someone interpret for me when I talk with my doctor?
Yes.

Who do I call for an interpreter?
Call Community Health Choice toll-free at 1.888.435.2850 TTY 711 to schedule an interpreter.

How far in advance do I need to call?
You must call at least three working days before your appointment.

How can I get a face-to-face interpreter in the provider's office?
Call Community Health Choice toll-free at 1.888.435.2850 TTY 711 to schedule an interpreter.

What if I need OB/GYN care?
Community Health Choice allows you to pick any OB/GYN, whether that doctor is in the same network as your Primary Care Provider or not.

Do I have the right to choose an OB/GYN?
You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor within the network

How do I choose an OB/GYN?
You can get OB/GYN services from your doctor. You can also pick an OB/GYN specialist to take care of your female health needs. An OB/GYN can help with pregnancy care, yearly checkups or if you have female problems. If you need assistance finding a Community Health Choice network OB/GYN or would like to request a Community Health Choice Provider Directory, you can call 1.888.435.2850. Call TTY: 7-1-1 for deaf and hard of hearing.

If I do not choose an OB/GYN, do I have direct access?
Yes, you have direct access. However, we encourage you to choose an OB/GYN so that you have one doctor who treats you throughout your pregnancy and knows your health needs.

Will I need a referral?
No.

How soon can I be seen after contacting my OB/GYN for an appointment? (Accessing requirements for perinatal care is within 2 weeks of request.)
Your OB/GYN is required to see you within 14 days from your request. Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days or immediately if an emergency exists.

Can I stay with my OB/GYN if they are not with Community Health Choice?
Yes, if you became eligible for Medicaid in the last three months of your pregnancy, you are allowed to see your current OB/GYN. If your OB/GYN is not a part of our network, please let us know so we may try to work with the Provider to ensure that you are able to continue to see the Provider. You may only see doctors and midwives who are Texas Medicaid Providers.

What if I am too sick to make a decision about my medical care?

If you have not named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Because those people may not all agree with what to do with your care, it is helpful if you say in advance what you want to happen if you can't speak for y1ourself.

What are advance directives?

Advance directives are legal papers that allow you to say if you would accept or refuse medical treatment if you become too ill to speak for yourself. These papers can help your family decide what to do for you to relieve them of the stress of making the decision for you. It also helps the doctor care for you according to your wishes.

How do I get an advance directive?

Ask your doctor for the form(s) for advance directives. Call Member Services toll-free at 1.888.435.2850 TTY 711 if you need more information.

What happens if I lose my Medicaid coverage?

If you lose Medicaid coverage but get it back again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

What if I get a bill from my Nursing Facility?

You should not get a bill for Medicaid-covered benefits.

Who do I call?

If you get a bill, call the Nursing Facility and tell them you are a Community Health Choice Medicaid Member and are not responsible for the bill.

What information will they need?

They will need information that is on your Member ID Card and information on the bill. If you still have a problem, call Member Services Department toll-free at 1.888.435.2850 TTY 711.

What is Applied Income, and what are my responsibilities?

It is the Member's personal income that the Member must provide to the Nursing Facility as part of their cost sharing obligation as a Medicaid beneficiary.

What are my responsibilities?

Any time Medicaid is billed by the Nursing Facility, the Member must give their applied income to the facility. The amount is determined by the total amount of monthly income divided by the number of days the Member resides in the facility each month. The Member is allowed to keep $60 for themselves for personal needs.

Can my Medicare provider bill me for services or supplies if I am in both Medicare and Medicaid?

You cannot be billed for Medicare "cost-sharing," which includes deductibles, coinsurance, and co-payments that are covered by Medicaid.

What do I have to do if I move?

As soon as you have your new address, give it to the local HHSC benefits office and Community Health Choice Member Services Department at 1.888.435.2850 TTY 711. Before you get Medicaid services in your new area, you must call Community Health Choice, unless you need emergency services. You will continue to get care through Community Health Choice until HHSC changes your address.

What if I have other health insurance in addition to Medicaid?

Medicaid and Private Insurance

You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your private health insurance is canceled.
- You get new insurance coverage.
- You have general questions about third party insurance.
- You can call the hotline toll-free at 1.800.846.7307.

If you have other insurance, you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

What are my rights and responsibilities?

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.
   c. Be given information about your health plan, services, and providers.
   d. Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.

d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

b. Get medical care in a timely manner.

c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

10. You have a right to make recommendations to your health plan's member rights and responsibilities.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

a. Learn and understand your rights under the Medicaid program.

b. Ask questions if you do not understand your rights.

c. Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

a. Learn and follow your health plan's rules and Medicaid rules.

b. Choose your health plan and a primary care provider quickly.

c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.

d. Keep your scheduled appointments.

e. Cancel appointments in advance when you cannot keep them.

f. Always contact your primary care provider first for your non-emergency medical needs.

g. Be sure you have approval from your primary care provider before going to a specialist.

h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

a. Tell your primary care provider about your health.

b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.

c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

a. Work as a team with your provider in deciding what health care is best for you.

b. Understand how the things you do can affect your health.

c. Do the best you can to stay healthy.

d. Treat providers and staff with respect.

e. Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1.800.368.1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Complaint Process

What should I do if I have a Complaint?

What should I do if I have a complaint about my health care, my provider, my service coordinator, or my health plan?

We want to help. If you have a complaint, please call us toll-free at 1.888.435.2850 TTY 711 to tell us about your problem. A Community Health Choice Member Services Advocate can help you file a complaint. Just call 1.888.435.2850 TTY 711. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Community Health Choice complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1.866.566.8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at: hhs.texas.gov/managed-care-help

Who do I call?

We want to help. If you have a complaint, please call us toll-free at 1.888.435.2850 to tell us about your problem. 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.

Once you have gone through the Community Health Choice complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free at 1.866.566.8989. If you would like to make your complaint in writing, please send it to the following address:

Can someone from Community Health Choice help me file a Complaint?

Yes. A Community Health Choice Member Advocate can help you file a complaint. Just call us toll-free at 1.888.435.2850 TTY 711. Most of the time, we can help you right away or, at the most, within a few days.

You can also write a letter or you can ask to complete a "Complaint Form." The Complaint Form must be returned to us for quick resolution.

Send your Complaint to the address below:

Community Health Choice Texas, Inc.
Service Improvement
4888 Loop Central Drive, Suite. 600
Houston, TX 77081
Fax: 713.295.7036

How long will it take to process my Complaint?

You can file a complaint at any time. We will send you a letter and a Complaint Form within five business days from the date we get your Complaint. This will let you know we got it. We will send you a resolution letter within 30 calendar days from the date we get your Complaint. We answer complaints about emergency care in one business day. We answer complaints about denials of continued hospital stays in one business day.

What are the requirements and timeframes for filing a Complaint?

There is no time limit on filing a complaint. Community Health Choice will send you a letter telling you what we did about your complaint.

- Information on how to file a Complaint with HHSC, once I have gone through the Community Health Choice Complaint process.

Appeal Process

What can I do if my doctor asks for a service or medicine for me that's covered but Community Health Choice denies it or limits it?

Community Health Choice will send you a letter if a covered service that you requested is not approved or if payment is denied in whole or in part. If you are not happy with our decision, call Community Health Choice within 60 days from when you get our letter. You must appeal within 10 Business Days of the date on the letter, or by the action effective date in the letter, to make sure your services are not stopped. You can appeal by sending a letter to Community Health Choice, by mailing the appeal form included in the letter you received, or by calling Community Health Choice. You can ask for an extension for up to 14 days of extra time for your appeal. Community Health Choice may take extra time on your appeal if it is better for you. If this happens, Community Health Choice will tell you in writing the reason for the delay. You can call Member Services and get help with your appeal. When you call Member Services, we will help you file an appeal. Then we will send you a letter and ask you or someone acting on your behalf to sign a form.

How will I find out if services are denied?

Community Health Choice will send you a letter if a covered service requested by your care provider is denied, delayed, limited or stopped.

- Timeframes for the Appeals process – Community Health Choice must complete the entire standard Appeal process within 30 Days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or Community Health Choice shows that there is a need for more information and how the delay is in the Member's interest. If Community Health Choice needs to extend, the Member must receive written notice of the reason for delay.

When do I have the right to ask for an appeal?

As a Member, you have the right to ask for an appeal if you disagree with Community Health Choice's answer or if you believe we made a mistake in denial of your requested medical services. You may ask for an appeal or call Community Health Choice Member Services to help in writing your appeal for submission to the Medical Appeals Department.

Call Community Health Choice Member Services at 1.888.435.2850 TTY 711 or send your appeal to:

Community Health Choice, Inc.
Attention: Medical Affairs-Medical Appeals Department
4888 Loop Central Drive, Suite. 600, Houston, TX 77081
Phone: 713.295.2300 or toll-free at 1.888.435.2850
Fax: 713.295.7033

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

Community Health Choice Texas, Inc. Attention: Medical Affairs-BH Appeals
P.O. Box 1411
Houston, TX 77230
713.295.2300 or toll-free at 1.888.435.2850 or TTY 7-1-1
Fax: 713.576.0394/ Attention: BH Appeals Coordinator

You may request an appeal for denial of payment for services in whole or in part. If you ask for an appeal within 10 days from the time you get the denial notice from the health plan, you have the right to keep getting any service the health plan denied or reduced at least until the final appeal decision is made. If you do not request an appeal within 10 Business Days from the time you get the denial notice, the service the health plan denied will be stopped.

- Include notification to Member that in order to ensure continuity of current authorized services, the Member must file the Appeal on or before the later of: 10 Days following the Community Health Choice's mailing of the notice of the Action or the intended effective date of the proposed Action.
- Appeals must be accepted orally or in writing.

Can someone from Community Health Choice help me file an Appeal?

Yes. A Community Health Choice Member Services Advocate can help you file an Appeal for denied medical services. Just call us toll-free at 1.888.435.2850 TTY 711. Most of the time, we can help you right away or, at the most, within a few days.

- Member's option to request an External Medical Review and State Fair Hearing no later than 120 days after the date the Community Health Choice mails the appeal decision notice.
- Member's option to request only a State Fair Hearing no later than 120 Days after the Community Health Choice mails the appeal decision notice.

Expedited Community Health Choice Appeal

What is an emergency Appeal?

An Emergency Appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an emergency Appeal?

You may ask for an emergency appeal from Community Health Choice orally or in writing. Do this if you believe that taking the time for a standard appeal resolution could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

Does my request have to be in writing?

No.

What are the timeframes for an emergency appeal?

If your appeal request has been determined to meet the criteria for an emergency review, Community Health Choice must complete an Emergency Appeal request review within 72 hours from the date and time of receipt of all the information we need to review the appeal. Community Health Choice will tell you our decision over the phone within 72 hours from the date that we have received all of the information we need to review the appeal. We will mail you our decision within three business days after a determination is made.

You will get a response within one business day if your appeal request is determined to meet emergency criteria and involves the following:

- Denial of Emergency Admissions and the Member is currently hospitalized
- Life Threatening Conditions

Denials of Continued Lengths of Stay for the condition for which the Member is currently hospitalized

What happens if Community Health Choice denies the request for an emergency Appeal?

If we deny the request for an emergency appeal, we will notify you within two calendar days. Then your request will be moved to the standard Medical appeal review process, and we will mail you our decision within 30 calendar days.

Who can help me file an emergency Appeal?.

Call Member Services toll-free at 1.888.435.2850 TTY 711 to speak with a Member Advocate who will help you with an Appeal or an Emergency Appeal.

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a Member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by contacting to name the person you want to represent you. A provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's internal appeal decision letter of the decision being challenged. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan at 4888 Loop Central Drive, Suite. 600, Houston, TX 77081 or call 1.888.435.2850 TTY 711.

You have the right to keep getting any service the health plan denied or reduced, at least until the final State Fair Hearing decision is made if you ask for a State Fair Hearing by the later of: (1) 10 calendar days following the date the health plan mailed the notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped. If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling Community Health Choice.

To qualify for an emergency State Fair Hearing through HHSC, you must first complete Community Health Choice's internal appeals process.

External Medical Review

Can I ask for an External Medical Review?

If you, as a Member of the health plan, disagree with the health plan's Community Health Choice Internal Appeal decision, you have the right to ask for an External Medical Review with State Fair Hearing. An External Medical Review is an optional, extra step you can take to get your case reviewed for free before your State Fair Hearing. You, your parent, your authorized representative or your legally authorized representative (LAR) must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the decision. If you do not ask for the External Medical Review within 120 days, you may lose your right to an External Medical Review. To ask for an External Medical Review, you, your parent, your representative or your legally authorized representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' that came with the Member Notice of Community Health Choice Internal Appeal Decision letter and mail or fax it to Community Health Choice by using the address or fax number at the top of the form.;
- Call Community Health Choice at 1.888.435.2850 TTY 711
- Email Community Health Choice at Appeals@communityhealthchoice.org,

You have the right to keep getting any service the health plan denied or reduced, at least until the External Medical Review and final State Fair Hearing decision is made if you ask for an External Medical Review with State Fair Hearing by the later of: (1) 10 calendar days following the Community Health Choice's mailing of the notice of the Action, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request continued benefits by this date, the service the health plan denied will be stopped.

You may withdraw your request for an External Medical Review before it is assigned to an IRO or while the IRO is reviewing your External Medical Review request. An External Medical Review cannot be withdrawn if an IRO has already completed the review and made a decision.

Once the External Medical Review decision is received, you have the right to withdraw the State Fair Hearing request. You may withdraw your State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Community Health Choice. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete Community Health Choice's internal appeals process.

Reporting Abuse, Neglect, and Exploitation

How do I report suspected abuse, neglect, or exploitation?

You have the right to respect and dignity, including freedom from Abuse, Neglect, and Exploitation.

What is Abuse, Neglect, and/or Exploitation?

Abuse is mental, emotional, physical, or sexual injury, or failure to prevent such injury.

Neglect results in starvation, dehydration, overmedicating or under medicating, unsanitary living conditions, etc. Neglect also includes lack of heat, running water, electricity, medical care, and personal hygiene.

Exploitation is misusing the resources of a person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

Reporting Abuse, Neglect, and Exploitation
The law requires that you report suspected Abuse, Neglect, or Exploitation, including unapproved use of restraints or isolation that is committed by a provider.

Call 9-1-1 for life-threatening or emergency situations

Report by Phone (non-emergency); 24 hours a day, 7 days a week, toll-free
Report to the Department of Aging and Disability Services (DADS) by calling 1.800.647.7418 if the person being abused, neglected, or exploited lives in or receives services from a:

- Nursing facility;
- Assisted living facility;
- Adult day care center;
- Licensed adult foster care provider; or.
- Home and Community Support Services Agency (HCSSA) or Home Health Agency,

Suspected Abuse, Neglect or Exploitation by a HCSSA must also be reported to the Department of Family and Protective Services (DFPS).

Report all other suspected abuse, neglect, or exploitation to DFPS by calling 1.800.252.5400.

Report Electronically (non-emergency):
Go to https://txabusehotline.org. This is a secure website. You will need to create a password-protected account and profile.

Helpful Information for Filing a Report
When reporting abuse, neglect, or exploitation, it is helpful to have the names, ages, addresses, and phone numbers of everyone involved.

Fraud Information

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184;
- Visit https://oig.hhs.texas.gov/ and click on "Report Fraud" to complete the online form; or
- You can report directly to your health plan:
  - Community Health Choice
  - 4888 Loop Central Drive, Suite. 600, Houston, TX 77081
  - 1.888.435.2850 TTY 711

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Information That Must Be Available on an Annual Basis

- As a Member of Community Health Choice you can ask for and get the following information each year:
- Information about network providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients, and, when applicable, professional qualifications, specialty, medical school attended, residency completion and board certification status.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal, External Medical Review and State Fair Hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and limits to those benefits.
- How you get emergency coverage and limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services, and post-stabilization services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - In case of emergency, follow instructions provided by your Nursing Facility. Facility staff will contact appropriate authorities to coordinate emergency transport and/or services.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
  - Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
  - Community Health Choices practice guidelines.

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

NON-DISCRIMINATION STATEMENT (HHS)

Community Health Choice, Inc. (Community) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Community provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Community provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Member Services Department at 1.888.435.2850. If you believe that Community has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance.

You can file a grievance in person or by mail, fax or email:

Service Improvement Department
4888 Loop Central Drive, Suite. 600
Houston, TX 77081

Phone: 1.888.435.2850 TTY 711
Fax: 713.295.7036
Email: ServiceImprovement@CommunityHealthChoice.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

Chinese 本通知有重要信息。本通知包含關于您透過Community Health Choice提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前采取行動，以保留您的健康保險或費用補貼。您有權免費以您的母語得到本訊息和幫助。請撥電話1.888.435.2850。

French Cet avis contient d'importantes informations. Cet avis contient d'importantes informations concernant votre demande ou votre couverture avec Community Health Choice. Consultez les dates figurant dans le présent avis car il est possible que vous ayez à prendre certaines mesures avant ces dates pour conserver votre assurance santé ou profiter de meilleurs coûts. Vous êtes en droit de recevoir ces informations et de bénéficier gratuitement d'une aide dans votre langue. Appelez le 1.888.435.2850.

Gujarati આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વિશે મહત્વની જાણકારી છે. આ નોટિસમાં મહત્વની તારીખો માટે જુઓ. તમારા આરોગ્ય કવરેજને રાખવા અથવા ખર્ચ બાબતે મદદ કરવા માટે અમુક ચોક્કસ મુદત સુધી પગલાં લેવાની તમારે જરૂર પડી શકે છે. તમને કોઈ પણ ખચર્ વિના તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.888.435.2850 પર કૉલ કરો.

Japanese こと通知には必要な情報が含まれています。この通知にはCommunity Health Choiceの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1.888.435.2850までお電話ください。

Laotian ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີ່ທີ່ສຳຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍໃຫ້ງການຊ່ວຍເຫຼືອໃນເລື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນສຳຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.888.435.2850.

Russian Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Community Health Choice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.888.435.2850.

Tagalog Ang Notisyang ito ay naglalaman ng Importanteng Impormasyon. Maayroon itong importanteng impormasyon tungkol sa inyong aplikasyon o pagpapaseguro sa pamamagitan Community Health Choice. Hanapin ang mga importanteng petsa sa notisyang ito. Maaaring may kailangan kayong gawin bago ang mga itinakdang deadline para manatiling nakaseguro o para matulungan kayo sa mga kailangang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalin sa inyong wika na wala kayong babayaran. Tawagan ang 1.888.435.2850.

Vietnamese Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về mẫu đơn của bạn hoặc bảo hiểm qua chương trình Community Health Choice. Xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải thực hiện trong thời gian nhất định để giử bảo hiểm sức khỏe của bạn hay giúp đỡ chi phí. Bạn có quyền được thông tin này và giúp đỡ trong ngôn ngữ của mình miễn phí. Xin gọi 1.888.435.2850.

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

Arabic

يتضمن هذا الإشعار معولمتا مهمة. وتتعلق هذه المعولمتا الهامة في الإشعار بخصاط صوبك أو التغطية تحت التأمين الصحي Community Health Choice. ابحث عن التوارخي الهامة في هذا الإشعار. ت دقحتجا لااتخنا إجراءاق تبل مواديء محددة للحافظ لاعى تأمنيك الصحي أو مستدعاك في دفع التاكلفي. ليدك الحق في الحصاء لوى هذه المعولمتا والمسابة دعاغتك دون فلكتي أة. اتصاء لى 1.888.435.2850 .

English

This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.888.435.2850.

German

Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag auf Krankenversicherung bzw. Ihren Versicherungsschutz mit Community Health Choice. Achten Sie auf wichtige Termine in dieser Mitteilung. Eventuell müssen Sie zu bestimmten Stichtagen Ma nahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.888.435.2850.

Hindi

इस सूचना में महत्वपूणर् जानकारी है। इस सूचना में आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूरण जानकारी है। इस सूचना में महत्वपूरण तारीखों के लिए खोजयि। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चत समय सीमा से कारर्वाइ करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता नि:शुल्क पराप्त करने का अधिकार है। 1.888.435.2850 पर कॉल कीजिए।

Korean

이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다.
1.888.435.2850 로 연락하십시오.

Persian

این اطلاعیه حاوی اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضانامه و پوشش بیمه ای شما توسط Community Health Choice می باشد. به تاریخ های ذکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگهداشتن پوشش بیمه ای با دریافت کمک هزینه، ممکن است نیاز باشد که تا مهلت های مقرر، اقداماتی را انجام دهید. حق شماست که این اطلاعات و کمک را بطور رایگان به زبان خودتان دریافت نمایید. با شماره تلفن 1.888.435.2850. تماس بگیرید.

Spanish or Spanish Creole

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.888.435.2850.

Urdu

ںیم سںوٹن سںا .ںیہ تامعلوم اہم ںیم سںوٹن سںا Community Health Choice ےع اپ کی درخواستیکے ذر ںنی صحت کےپے – ایھکیوں کو دخیراتاہم ںیم سںوٹن سںا -ںیہ تامعلوم علق اھم‌تم حفظ سےت ے کیںمیبہ ایہ ےنرائی کورراک کت وںخیرات صاےے آپ کو کچھ خیل د کےدم ںیم تااجراخ ای ار رکھنےرقرحفظ کو بت ے کےمیبہ رپ .ہے لصاح قح اےے کنرک لصاح فتم ںیم نانی زبپد کو ادم روا تامعلوم ںآپ کو ا .ںیی ہتکہوس تروکی ض 1.888.435.2850 .ںیرک ہرابط

Member Events

Community is always planning great events, big and small, for our Members in the Houston and Beaumont areas!
Do you have an event suggestion? Email it to CommunityAffairs@CommunityHealthChoice.org.



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