

STAR+PLUS

OCTOBER 2026

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

SPMHB_OCT2026 0063991

IMPORTANT PHONE NUMBERS

1.888.435.2850 713.295.2300	**Member Services** 24 hours a day, 7 days a week, Monday – Friday, 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.
1.866.566.8989	**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 for Hearing-Impaired
1.800.206.9052	**24-Hour Nurse Advice Line** Information is available in English and Spanish. 7-1-1 TTY for Hearing Impaired. Call us to get an interpreter. In case of an emergency, call 9-1-1 or go to the nearest hospital.
1.833.502.0131	**STAR+PLUS Non-Emergency Medical Transportation (NEMT) – MTM Health** Call to schedule and to check the status of your ride. **MTM Health** is available 24 hours a day, 7 days a week. Call MTM Health toll-free at **1.833.502.0131 (7-1-1 for TTY)**, visit **https://mtm.mtmlink.net** from any web browser on your computer or mobile device, or download the **MTM Link** scheduling app from your smartphone's app store. Make sure to allow at least 2 business days before your ride. Information is available in English and Spanish. Call MTM Health to get an interpreter. In case of an emergency, call 9-1-1 or go to the nearest hospital.

IMPORTANT PHONE NUMBERS

1.888.435.5150	**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/TDD line at 7-1-1
1.844.686.4358	**Vision Services** Envolve Vision visionbenefits.envolvehealth.com
1.877.727.9570	**Dental Services** FCL Dental
1.888.435.2850	**Pharmacy** Community Health Choice Member Services 8:00 a.m. – 5:00 p.m., Monday – Friday, excluding state-approved holidays.

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.

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

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.

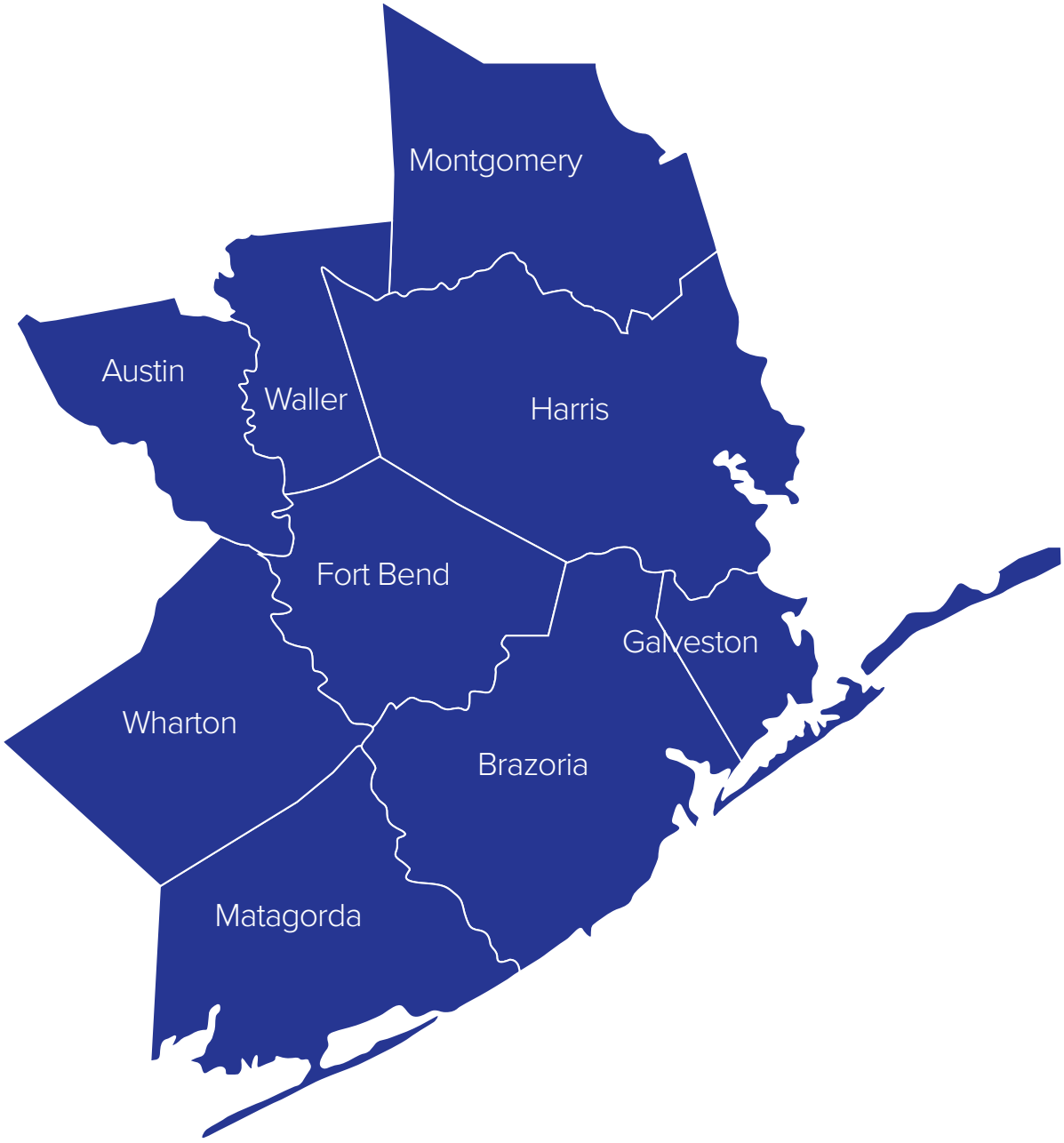
If you need auxiliary aids and services, including getting materials in alternative formats like large print or Braille, please call the HHSC Eligibility Office toll-free at 1.855.827.3748 or our Member Services Department toll-free at 1.888.435.2850.

Need help? 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.

Service Area Map



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Information That Must be Available as a Community Health Choice Member 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 who are not accepting new patients.
- 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.
- Information about In-Lieu-Of Services and Settings, if offered by your MCO, including amount, duration and scope of benefits and the policy on referrals.
- How you get benefits, including family planning services, from out-of-network Providers and limits to those benefits.
- How you get after hours and 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.
  - How to get emergency services, including instructions on how to use the 9-1-1 telephone system or its local equivalent.
  - 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 Choice's practice guidelines.

Important Things to Remember

We are here to help you get the most from your health coverage.

Here are some important things to remember:

- Read this handbook. If you have any questions about this handbook, call Member Services toll-free at 1.888.435.2850.
- Read your Rights and Responsibilities as a plan Member in this handbook.
- Find a Primary Care Provider in our online Provider Directory. If you need help finding a Provider, call Member Services toll-free at 1.888.435.2850. When you pick your Provider, you must call us so we can assign that Provider to you. You can also create an online account at www.CommunityHealthChoice.org > Member Login and choose your Primary Care Provider.
- You will receive your Community Health Choice Member ID card within 3–5 business days after you have told us who you have chosen to be your Primary Care Provider. Review your information on the card. If there are any errors, contact us immediately.
- Show your Community Health Choice Member ID card every time you go to the doctor's office, clinic, hospital or drug store to get your prescription filled.
- If you have special healthcare needs, we can help! We can enroll you in one of our Care Management Programs or refer you to Case Management for Children and Pregnant Women Program.
- If you are a Member of a traveling farmworker family, we can help you get all the healthcare services you need before you travel.
- Always carry your Community Health Choice Member ID card with you.
- Keep this handbook in a safe place for future use.

Remember, we are here to help. Call Member Services toll-free at 1.888.435.2850 for assistance.

In addition to these, Community Health Choice believes you have the the following rights and responsibilities:

Rights

1. A right to receive information about the organization, its services, its practitioners and Providers, and Member rights and responsibilities.
2. A right to be treated with respect and recognition of your dignity and your right to privacy.
3. A right to participate with practitioners in making decisions about your health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's Member rights and responsibilities policy.

Responsibilities

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

8. A responsibility to follow plans and instructions for care that you have agreed to with their practitioners.
9. A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the extent possible.

You have a right to tell us what you think of the rights and responsibilities offered to you. Tell us what you think at 1.888.435.2850.

New Technology Assessment

We provide for care that is shown to be safe and useful. We review new healthcare treatments. We review new procedures. The review uses up-to-date health data. This is called New Technology Assessment. We decide whether to pay for these things. This review means we pay when safety and value is clear. You may ask us to review new technology. The Texas Vendor Drug Program reviews medications. They decide which medications are on the formulary.

Utilization Management Decisions

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

1. Our decisions are based only on whether or not:
   - The care and services are appropriate.
   - It is a covered benefit.
2. We do not reward doctors or anyone else for denying coverage.
3. We do not give incentives to doctors or anyone else to encourage them to make decisions that would mean you would get less care than you need.
4. If Community denies your request for services, you can get an independent external review. An independent review is when someone not employed by Community reviews your request for services. This is called a Fair Hearing.

Quality Improvement

Our Quality Improvement Department helps Community give you the best clinical care and service possible. The Quality Team observes, analyze, and improve the quality methods in order to improve healthcare outcomes for our members. If you want more information about our Quality Improvement Program, please contact Member Services toll-free at 1.888.435.2850.

Moral or Religious Objections

Community Health Choice does not exclude access to any services because of moral or religious objections.

How Community Health Choice Works

Benefits of Joining Community Health Choice

We have a big network of doctors, hospitals, and other health Providers. Our Member Services Department is here to help you! You can call Member Services toll-free at 1.888.435.2850, 8:00 a.m. – 5:00 p.m., Monday – Friday, excluding state- approved holidays. We speak English and Spanish or can get you an interpreter who speaks your language.

Our Member Services staff can help you:

- Answer questions about benefits
- Choose a Primary Care Provider (Doctor)
- Change your Primary Care Provider
- Get a new Member Identification (ID) Card if yours is lost or stolen
- Solve complaints or problems
- Answer pharmacy questions

You can also access your My Member Account online 24 hours a day, seven days a week to:

- Check your eligibility
- Change your address, phone number or Primary Care Provider
- Find out if you are due for an exam
- R.S.V.P. for events
- Ask us a question

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



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.
- 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 at 1.888.435.2850.

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a Your Texas Benefits 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 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.

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.

1. First pick a language and then pick option 2.

Your health history 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 health history through the secure online network, call toll-free at 1.800.252.8263.

The Your Texas Benefits 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 Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Texas Women's Health Program (TWHP)
  - Hospice
- 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
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE)

The back of the Your Texas Benefits Medicaid Card has a Web site 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

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids 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. A Legally Authorized Representative may view the information of anyone who is a part of their case.

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 do I need to bring with me to my doctor's appointment?

When you go to see your doctor, take your Member ID Card, Your Texas Benefits Medicaid Card, a list of problems you are having, a list of any drugs or herbal medicines you are taking, and a record of all shots you have had.

Remember: EXCEPT IN AN EMERGENCY, CALL YOUR PRIMARY CARE PROVIDER FIRST BEFORE GOING FOR HEALTHCARE.

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**. We will assign your selected Primary Care Provider.

For a current directory, go to www.CommunityHealthChoice.org > Find a Doctor > Medicaid/CHIP > 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. Schedule your child's first Texas Health Steps medical checkup right away.

We can help you schedule your first checkup and get transportation to your Provider's office. Call **MTM Health** toll-free at **1.833.502.0131 (7-1-1 for TTY)**, visit **https://mtm.mtmlink.net** from any web browser on your computer or mobile device, or scan the appropriate QR code below to get the MTM Link scheduling app.

ACCESSING MTM LINK

IOS Devices  Android Devices 

Can a specialist ever be considered a Primary Care Provider?

Yes. Members with disabilities, special healthcare needs or chronic or complex conditions may ask Community Health Choice to use a specialist as their Primary Care Provider. Please call Member Services toll-free at 1.888.435.2850.

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
- Writing us at:

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

- Creating a My Member Account and changing it online at www.CommunityHealthChoice.org

Can a clinic be my Primary Care Provider? (Rural Health Clinic/Federally Qualified Health Center)

Yes. A rural health clinic (RHC) or federally qualified health center (FQHC) can be your Primary Care Provider.

An RHC provides healthcare services in rural, underserved areas. An FQHC provides healthcare services in both rural and urban underserved areas.

Who else can be my Primary Care Provider?

You may choose:

- Family doctors
- General Practice doctors
- Internal Medicine doctors
- Advanced Nurse Practitioners (ANPs)
- Pediatricians (for children and adolescents)

How many times can I change my Primary Care Provider?

There is no limit on how many times you can change your or your child's Primary Care Provider. You can change your Primary Care Provider by:

- Calling us toll-free at: 1.888.435.2850
- Writing us at:

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

- Creating an account and changing it online at www.CommunityHealthChoice.org

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.

Are there any reasons why a request to change a Primary Care Provider may be denied? Sometimes, a Primary Care Provider you choose may not be available. Our Member Services will help you pick another Primary Care Provider. Here are reasons you may not be able to see a Primary Care Provider:

- The Primary Care Provider you picked is not seeing new patients.
- The Primary Care Provider you picked is no longer part of our network.

Can my Primary Care Provider move me to another Primary Care Provider for non-compliance?
Yes, here are some reasons:

- You do not follow your Member Responsibilities listed in this Member Handbook
- You miss three appointments in a row within six months and you do not call ahead to cancel
- You do not follow your Provider's healthcare recommendations
- You are rude, abusive or do not cooperate with the Provider or office staff Member Services will call you and help you get a new Primary Care Provider.

What if I choose to go to another doctor who is not my Primary Care Provider?
Except in emergencies, always call your Primary Care Provider before you go to another doctor or the hospital. You can reach your Primary Care Provider or back-up doctor 24 hours a day, seven days a week. If you go to another doctor who is not your Primary Care Provider, you may need to pay the bill.

How do I get medical care after my Primary Care Provider's office is closed?
You should call your Primary Care Provider. You can reach your doctor or a back-up doctor 24 hours a day, seven days a week. Or you may call our 24-Hour Nurse Advice Line toll-free at 1.800.206.9052. Our nurses help you get the right healthcare for your problem. In an emergency, call 9-1-1 or go to the nearest emergency room.

What is the Medicaid Lock-in Program?
You may be put 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 MCO will not change the Lock-in status.

To avoid being put 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 toll-free at 1.888.435.2850.

Physician Incentive Plan Information

Community Health Choice cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. 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 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 Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at 1.800.964.2777. You can change health plans as often as you want.

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?

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 Medicaid 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 NEMT 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 provideradministered outpatient drugs and biologicals, and drugs and biologicals provided in an inpatient setting;
24. PAS (State plan);
25. PCS for Members under 21 years of age;
26. Podiatry;
27. Prenatal care;
28. PPECC services for Members under 21 years of age;
29. Preventive services including an annual adult well check for patients 21 years of age and over;
30. Primary care services;
31. PDN services for Members under 21 years of age;
32. Radiology, imaging, and X-rays;
33. Specialty physician services;
34. Specialty Therapies – physical, occupational and speech therapies;
35. Transplantation of organs and tissues;
36. 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.);
37. Telemedicine;
38. Telemonitoring, to the extent covered by Tex. Gov't Code § 531.0216; and
39. 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.

STAR+PLUS HCBS:

1. STAR+PLUS HCBS PAS;
2. Nursing services (in-home);
3. Emergency response services (emergency call button);
4. Home delivered meals;
5. Dental services;
6. Respite care, including in-home or out-of-home respite;
7. Minor Home Modifications;
8. Adaptive Aids and medical supplies;
9. Specialty Therapies;
10. Adult foster care;
11. Assisted living;
12. Transition Assistance Services (TAS);
13. Cognitive rehabilitation therapy;
14. FMS;
15. Support consultation;
16. 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.
17. Supported employment;

How do I get these services?

You can get information about these services by calling Member Services Toll Free at: 1.888.435-2850 TTY.

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 my Long-Term Services and Supports (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
- Personal Care Attendant
- Respite Care Services

- Consumer Directed Servcies
- Emergency Response Services
- Home Delivered Meals
- Minor Home Modifications
- Nursing Facility Services
- Therapy Services (physical, occupational, speech)
- Protective Supervision
- Transition Assistance Services
- Dental Services
- Cognitive Rehabilitation Therapy

Consumer Directed Services

What is Consumer Directed Services?

Consumer Directed Services (CDS) allows you the ability to have more choices and control over some of the long-term support services you get. As a STAR+PLUS member, you can choose the CDS options you want to manage.

With CDS you can:

- Find, screen, hire and fire (if needed) the people who provide services to you (your staff)
- Train and direct your staff

These are the services you can manage in CDS:

- Attendant Care
- CFC Habilitation
- CFC Personal Assistance Service
- Cognitive Rehabilitation Therapy
- Employment Assistance Nursing
- Occupational Therapy
- Physical Therapy
- Respite Care
- Speech Therapy
- Support Consultation
- Supported Employment

If you choose to be in CDS, you will contract with a Financial Management Services Agency (FMSA). The FMSA will help you get started and train you and support if you need it. The FMSA will do your payroll and file your taxes. Contact your Service Coordinator to find out more about CDS. You can call our Service Coordination Team at 1.888.435.5150 toll-free TTY 7-1-1 or you can always call the Member Service as well. 1.888.435.2820 toll-free TTY 7-1-1.

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.

How do I get these services?
You can get information about these services by calling Member Services Toll Free at: 1.888.435-2850.

What number do I call to find out about these services?
You can get information about these services by calling Member Services Toll Free at: 1.888.435-2850.

Do I have access to out-of-network services?
We provide Members with out-of-network services that are medically necessary and covered benefits that are not available in our network. If those services become available, Members will need to go to one of our network Providers. Prior authorization is required except for emergency situations.

What services are not covered?
- Abortions not covered by federal and state regulation;
- Acupuncture;
- Autopsies;
- Cosmetic or plastic surgery that is not medically necessary;
- Custodial care;
- Experimental surgery;
- Eye surgery for correcting nearsightedness, farsightedness or blurring;
- Infertility treatment, including artificial insemination and in-vitro fertilization;
- Personal convenience items like television, telephones or grooming supplies or services, unless medically necessary;
- Prosthetic and orthotic devices;
- Reversal of voluntary sterilization;
- Out-of-area routine healthcare;
- Services not approved by your Primary Care Provider or Community Health Choice, except emergencies;
- Services provided by your employer or a close relative; and
- Sex change surgery

Will my STAR+PLUS benefits change if I am in a Nursing Facility?
Your STAR+PLUS benefits will not change if you are in a Nursing Facility. 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 Member Services at 1.888.435-2850. Please remember that if you have Medicare and Medicaid your acute care benefits are covered by Medicare.

How do I get these services?
Call your primary care provider and let the office know what service you need. Your doctor will help you get the services you need. For some of the services listed you can go directly to the provider that gives the services. Call Member Services at 1.888.435-2850.

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

Call your primary care provider and let the office know what service you need. Your doctor will help you get the services you need. For some of the services listed you can go directly to the provider that gives the services. Call Member Services at 1.888.435-2850.

What other services can Community Health Choice assist me with?

We can assist you with Adoption Assistance and Permanency Care Assistance (AA/PCA), Women, Infants and Children (WIC), and Early Childhood Intervention (ECI).

Community offers application and recertification assistance out in the community. Call Member Services to find the assistance site closest to you.

What is Women, Infants, and Children (WIC)?

WIC is a nutrition program for women, infants, and children. WIC helps pregnant women and new mothers learn more about food, breastfeeding, formulas, nutrition, and healthy eating. WIC may help by giving WIC vouchers for healthy foods. Call Member Services to find a WIC office near you.

What is Service Coordination?

Service Coordination is the coordination of medical services to help you with your medical needs. A Service Coordinator will:

- Help you choose a Primary Care Provider
- Teach you how and when to use the 24-hour Nurse Advice Line
- Give you information about illness and medication
- More

What will a Service Coordinator do for me?

Service Coordination is there to help you obtain the services that you may need. Service Coordinators help manage your healthcare needs and assist with obtaining long-term care including access to community based resources as well as help with obtaining food and housing. The Service Coordinator will work with providers such as your primary care doctor, specialists and non-medical medical providers and create a plan of care that meets your needs. Call the Service Coordination Hotline toll-free at1.888.435.5150 for help.

What are my prescription drug benefits?

Community follows the Texas Vendor Drug Formulary for STAR+PLUS. Updates to the formulary are managed by the Texas Vendor Drug Program.

Here is how to search:

- Visit the formulary at https://www.txvendordrug.com/formulary/formulary-search.
- Enter the name of your drug.

This search will tell you:

- If the drug is on the formulary
- If the drug requires a prior authorization

Drugs are listed as “preferred” and “non-preferred.” If you need a “non-preferred” drug, your doctor will need to submit a special request to get the “non-preferred” drug by calling Member Services toll-free at 1.888.435.2850.

What Extra Benefits do I get as a Member of Community Health Choice?

Value-Added Services are effective September 1, 2025 to August 31, 2026. Limitations may apply. If you have any questions, call Member Services toll-free at 1.888.435.2850.

VALUE ADDED SERVICES	
Extra Help with Getting a Ride	Rides to an appointment with an additional family member or caregiver including food bank, food pantry, grocery shopping, Community sponsored events, and senior recreational events
Disease Management	Diabetic shoe insoles for Members with diabetes and enrolled in Community Case Management or Disease Management program
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)
Extra Vision Services	Members may opt-out of standard eyewear benefit and use $150 towards purchase of non-standard glasses or contacts, including contact fitting fee, every 24 months
Discount Pharmacy/ Over-the-Counter Benefits	Members receive $10 per month (up to $120 annually) for over-the-counter-medicines and other health related supplies not covered by Medicaid
Help for Members with Asthma or COPD	Members with Asthma or COPD who are enrolled in Community's Disease/Case Management program get: • Asthma educational materials • One allergy-free mattress cover • One allergy-free pillowcase
Extra Help for Pregnant Women	Members receive a $25 gift card for completing a prenatal checkup within 42 days of enrollment and a $25 gift card for completing a timely postpartum checkup within 21- 84 days after giving birth. App for pregnancy tracking, education, and planning
Home Visits	Companionship Home Visits, up to 48 hours annually, for STAR+PLUS non-waiver Members
Health and Wellness Services	• Ten (10) home delivered meals after getting out of the hospital for STAR+PLUS non-HCBS Members • Access to a nutritionist for dietary education and weight management and/or loss • Free pill organizer • Free flashlight • Free lighted magnifying glass for newly-enrolled. STAR+PLUS Nursing Facility Members • Free photo frame for for newly-enrolled. STAR+PLUS Nursing Facility Members • Free blanket for newly-enrolled. STAR+PLUS Nursing Facility Members • Free digital, large display clock for newly-enrolled STAR+PLUS Nursing Facility Members • Free pair of non-skid socks for newly-enrolled STAR+PLUS Nursing Facility Members

VALUE ADDED SERVICES	
Healthy Play and Exercise	$100 allowance towards an annual Baker Ripley membership for services including: • adult skill-building (including digital skills), food and nutrition services, health promotion, wellness, exercise and social engagement activities Exercise kit for newly-enrolled STAR+PLUS Nursing Facility Members, which includes: • One resistance band • One heavy resistance band • One pedometer
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 diabetes screening • $30 gift card each year for current female Members who get a recommended mammogram
Online Mental Health Resources	• Online telehealth resources • Online companionship tool • Online mental health program for individual and group therapy, aftercare services and medication management for Members aged 21 - 32

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

- Member Events – We hold events that are only for Members and their guest(s) throughout the year.
- Help with recertification for Medical benefits

We can help you with recertification for Medicaid when it is time for you to get recertified. You can call and get help over the phone or at one of our application sites. Visit www.communityhealthchoice.org. Search “Application Assistance” for more information.

How can I get these benefits?

Call Member Services at 713.295.2300 or toll-free at 1.888.435-2850.

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.

What other services can Community Health Choice help me get?

- Case Management/Service Coordination
- Mental Health and Mental Retardation (MHMR) Health Rehabilitation
- Texas School Health and Related Services
- Tuberculosis Service provided by a Health Science Center (HSC)-approved Provider
- Medical Transportation
- Health and Human Services Commission (HHSC) Hospice Services
- For more information, please contact Community Health Choice toll-free at 1.888.435.2850, Monday to Friday, 8:00 a.m. to 5:00 p.m.

Health Care and Other Services

Community Health Choice cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. 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 (1.88.435.2850) to learn more about this.

What does Medically Necessary mean?

Medically Necessary means:

(1) For Members over age 20, non-behavioral health related healthcare 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 healthcare practice guidelines and standards that are endorsed by professionally recognized healthcare 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 over age 20, 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.

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.

What is urgent medical care?

Another type of care is urgent care. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts
- Earaches
- Sore throat
- Muscle sprains/strains

What should I do if I need urgent medical care?

For urgent care, you should call your doctor's office, even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Community Health Choice Medicaid.

For help, call us toll-free at 1.888.435.2850. You can also call our 24-Hour Nurse Advice Line at 1.800.206.9052 for help with getting the care you need.

How soon can I expect to be seen?
You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Community Health Choice Medicaid.

What are Long Term Care and Support Services (LTSS)?
Long-term Services and Supports (LTTS) Services include Primary Home Care, Day Activity and Health Services, and the STAR+PLUS HCBS program, that assist members in the community. 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 Services
- 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 do I get these services?
Members must qualify for LTSS Services, please contact Community Health Choice for additional information at 1.888.435.2850.

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 woman, 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 who 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?

You should be seen immediately for emergency, medical or behavioral health services.

Does my coverage include hospitals?

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

Are Emergency Dental Services Covered by Community Health Choice?

Community Health Choice covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for dislocated jaw
- Treatment for traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Hospital, physician, and related medical services such as drugs for any of the above conditions.

What do I do if I need Emergency Dental Care?
During normal business hours, call your Main Dentist to find out how to get emergency services. If you need emergency dental services after the Main Dentist's office has closed, call us toll-free at 1.888.435.2850 or call TTY 7-1-1.

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

How do I get medical care after my Primary Care Provider's office is closed?
You should call your Primary Care Provider. You can reach your doctor or a back-up doctor 24 hours a day, seven days a week. Or you may call our 24-Hour Nurse Advice Line toll-free at 1.800.206.9052. Our nurses will help you get the right healthcare for your problem. In an emergency, call 9-1-1 or go to the nearest emergency room.

What if I get sick when I am out of town or traveling?
If you need medical care when traveling, call us toll-free at 1.888.435.2850 and we will help you find a doctor. If you need emergency services while traveling, go to the nearest emergency room, then call us toll-free at 1.888.435.2850.

What if I am out of the state?
If you need emergency services while traveling, go to a nearby hospital.

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. Sometimes you may need care from a specialist. Your Primary Care Provider will help you find a specialist. You may also need Non-emergency hospital care. Your Primary Care Provider will refer you to a hospital if needed. Members with disabilities, special healthcare needs and chronic or complex conditions may have direct access to a specialist.

What is a referral?
A referral is a consultation for evaluation and/or treatment of a patient requested by one doctor to another doctor. Community Health Choice will not pay the cost of Non-emergency hospital care or medical equipment unless your Primary Care Provider gives you a referral.

How soon can I expect to be seen by a specialist?
The specialist will see you as soon as possible, usually within 8 to 10 weeks. Of course, if it is urgent, the specialist may be able to see you within 24 hours of your request. If you need help or cannot wait that long, call Member Services, and we may be able to find another specialist you can visit sooner.

What services do not need a referral?
- Emergency care
- OB/GYN care

- Texas Health Steps medical and dental checkups
- Family planning services
- Behavioral (mental) health services or drug and alcohol treatment

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 (mental) health, alcohol or drug problems?

If you child have a problem with drugs, alcohol or mental health or needs urgent care, call Community Health Choice toll-free at 1.888.435.2850, 24 hours a day, 7 days a week.

Do I need a referral for this?

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, 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?

These are special services for children and eligible adults. Children must have a serious emotional disturbance. Eligible adults must have a diagnosis of serious mental illness.

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.

What are In-Lieu-Of Services and Settings?

In-lieu-of services and settings (ILOSs) are special kinds of health care services. They are approved by Health and Human Services and can be used instead of going to a hospital. These services are medically right for you, can cost less and may be more convenient or better for your needs. If you need help for a mental health condition or a substance use disorder, you might be offered one of these services instead of staying in a hospital. You can choose the one that works best for you.

These services include:

- Partial Hospitalization Services (PHP)
- Intensive Outpatient Services (IOP)
- Coordinated Specialty Care (CSC) services.

What is Intensive Outpatient Services (IOP)?

Intensive Outpatient Services (IOP) is a program that gives care for at least 10 hours a week for 4 to 12 weeks. You don't stay overnight. This is for people who have mental health, substance use disorder (SUD), or both.

IOP includes:

- Services where you don't live at the center (non-residential)
- Group and one-on-one therapy (structured)
- Learning programs (educational services)
- Life skills training.

What is Partial Hospitalization Services (PHP)?

Partial Hospitalization Services (PHP) is a short-term program that is like staying at a hospital, but you don't sleep there. It gives stronger care than regular outpatient services. This is also for people with mental health, SUD, or both.

PHP includes:

- A full day of planned mental health services
- One-on-one, family, and group therapy (psychotherapy)
- Counseling for SUD
- Medication-Assisted Treatment (MAT)
- Occupational Therapy

What is Coordinated Specialty Care (CSC)?

Coordinated Specialty Care (CSC) is for people ages 15–30 who have had early psychosis in the last two years. Community Health Choice will offer CSC services October 1, 2025.

CSC includes:

- Full mental health services
- A care plan made just for you by a team
- Mental health check-ups (Psychiatric Diagnostic Interview Examination)
- Help with daily tasks (Routine Case Management)
- Skill-building programs (Psychosocial Rehabilitation)
- Support from people with similar experiences (Peer Support)
- Help with medicines and shots (Pharmacological Management and Injection)
- Learning how to take medicine safely
- Counseling for individuals and groups
- Help with housing and getting a job
- Activities to help you stay involved
- Extra support money (Flexible Funds)
- Extra Services that may be included:
- Flexible Community Supports
- SBIRT – a short talk, check-in, and help if needed (Screening, Brief Intervention and Referral to Treatment)

How can I get these services?

ILOSs do not replace regular health services. If your doctor says you need certain care, you can still get that through your plan. But if you think one of these services would work better for you, you or your parent/guardian can contact us to talk about it.

How do I get my medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store or may be able to send the prescription for you.

How do I find a network drug store?

Look in our Provider Directory. Call Member Services toll-free at 1.888.435.2850. Or look on our Web site at www. CommunityHealthChoice.org > Find a Doctor > Find a Pharmacy.

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 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?

Bring your:

- Prescription
- Community ID Card
- Your Texas Benefits Medicaid Card

What if I need my medications delivered to me?

Community Health Choice also offers many medications by mail. Some Community Health Choice drug stores offer home delivery services. Call Member Services at 1.888.435.2850 to learn more about mail order or to find a drug stores that may offer home delivery service in your area.

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

Call Member Services toll-free at 1.888.435.2850. We can help you find a drug store in our network that is close to you.

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 toll-free at 1.888.435.2850 for help with your medications and refills.

What if I lose my medication(s)?

Call Member Services toll-free at 1.888.435.2850 for instructions on what you need to do.

What if I also have Medicare?

You can get STAR+PLUS even if you get Medicare unless you get Medicaid 1915 (c) waiver services or live in facilities for people with Intellectual Developmental Disabilities (IDD).

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.

How do I get my medications if I am in a Nursing Facility?
Community Health Choice also offers many medications by mail. Some Community Health Choice drug stores offer home delivery services. Call Member Services at 1.888.435.2850 to learn more about mail order or to find a drug stores that may offer home delivery service in your area.

What if I needs an over-the-counter medication?
Some over-the-counter medications are part of your Medicaid benefit. You need a prescription from your doctor.

How do I get family planning services?
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 for help in finding a family planning provider.

Do I need a referral for this?
You do not need a referral.

Where do I find a family planning services Provider?
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 for help in finding a family planning Provider.

What is Case Management for Children and Pregnant Women (CPW)?
Case Management for Children and Pregnant Women
Case Management for Children and Pregnant Women (CPW)—CPW provides services to children (birth to age 20) with a health risk and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care.

For more information, please contact Community Health Choice toll-free at 1.888.760.2600, Monday to Friday, 8 a.m. to 5 p.m. or call Texas Health Steps toll-free at 1.877.847.8377, Monday to Friday, 8 a.m. to 8 p.m.

Who can get a case manager?
Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- have health problems, or
- are at a high risk for getting health problems.

What do case managers do?
A case manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?

Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?

Contact Community Health Choice for more information Monday to Friday, 8 a.m. to 5 p.m. or call Texas Health Steps at 1.877.847.8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

- Community Health Choice Case Management toll-free at 1.888.435.2850
- www.CommunityHealthChoice.org

What is Service Coordination?

Service Coordinator will assist will the coordination of medical services to help you with your medical needs. The Service Coordinator will:

- Help you choose a Primary Care Provider and organize care with your Primary Care Provider
- Teach you how and when to use the 24-hour Nurse Advice Line
- Give you information about illness and medication and explain and describe service and placement choices to you
- Advocate and work with your healthcare team and help with any medical, behavioral health and Long-Term Services and Supports
- 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
- Find ways for you to live at home or in other community settings

How can I talk with a Service Coordinator?

To speak with a Service Coordinator, please call Member Services at Service Coordination Team at 1.888.435.5150. TTY: 7-1-1 for deaf and hard of hearing.

How can I get Service Coordination?

You are assigned a Service Coordination when you join in Community Health Choice STAR+PLUS plan. Your Service Coordination will call you, or visit you in person, to talk to you about your health care needs and tell you more about the services you can get. He or she will ask you questions about your health and the support you need. Your Service Coordinator will keep anything you talk about private. To speak with a Service Coordinator, please call 1.888.435.5150. TTY: 7-1-1 for deaf and hard of hearing.

What is a traveling farmworker?

A traveling farmworker moves from place to place and lives away from home for more than a few days at a time to work on a farm or in fields. These jobs include preparing crops, growing vegetables and fruits, planting trees, raising or caring for livestock or poultry or preparing dairy products. Children of traveling farmworkers, age birth through age 17, can get healthcare services early before they move with you to go to the next farm job. We want your child to get the healthcare services they need. We can help you set up a Texas Health Steps checkup appointment or dentist visit quickly before they move with you to your next job. We can also arrange rides at no cost to and from the doctor, dentist, hospital or drug store. Please

call toll-free at 1.888.435.2850 to find out how Community Health Choice can help your child stay healthy.

What if I am a traveling farmworker?

You can get your checkup sooner if you are leaving the area.

Non-emergency Medical Transportation (NEMT) Services

What Non-emergency Medical Transportation (NEMT) Services are available to me?

What are NEMT Services?

NEMT Services provide transportation to non-emergency health care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and any other places you get Medicaid services. These trips do NOT include ambulance trips. MTM Health is Community's NEMT transportation service.

What services are part of NEMT's Services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized MTM Health services

If you need an attendant to travel to your appointment with you, MTM Health will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if

How to get a ride

Call **MTM Health toll-free** at **1.833.502.0131 (7-1-1 for TTY)**, visit **https://mtm.mtmlink.net** from any web browser on your computer or mobile device, or **scan the appropriate QR code below** to get the **MTM Link** scheduling app.

ACCESSING MTM LINK

IOS Devices  Android Devices 

You should request MTM Health as early as possible, and at least two business days before you need the MTM Health service. In certain circumstances, you may request the MTM Health 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 MTM Health prior to the approved and scheduled trip if your medical appointment is cancelled.

How do I find out where my ride is?
You can call 1.833.502.0131 to find out the status of your ride.

How do I get eye care services?
Call the vision provider listed on page 2, "Important Phone Numbers." In Medicaid, eye care services are different for adults and children. If you are over 21, you can get an eye exam and glasses every two (2) years. You cannot get your glasses replaced if you break or lose them. With Community Health Choice, you get extra vision benefits too. Call Envolve Vision Services, Community Health Choice vision provider, at 1.844.686.4358,

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 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 to schedule an interpreter.

What if I need OB/GYN care?
ATTENTION FEMALE MEMBERS
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 choose any OB/GYN listed in our Provider Directory under "Women's Health Services Providers." It is very important to choose a doctor to take care of you while you are pregnant. Call Member Services if you are pregnant and need help choosing an OB/GYN.

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?
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 pregnant?
You may receive prenatal care without a referral. Your OB/GYN must request referral authorization for some tests and procedures. Your OB/GYN must notify Community Health Choice of pregnancy care visits.

Who do I need to call?
If you are pregnant, call your Medicaid Case Worker and Member Services right away.

What other services/activities/education does Community Health Choice offer pregnant women?
We will provide you with maternity educational materials upon request.

Where can I find a list of birthing centers?
Please look at the "Hospital List" in your STAR+PLUS Provider Directory. Our "Level III Birthing Centers" have a stork with baby picture next to them. The directory is also online at www.CommunityHealthChoice.org > Find a Doctor.

Can I pick a Primary Care Provider for my baby before the baby is born?
Please look at the "Hospital List" in your STAR+PLUS Provider Directory. Our "Level III Birthing Centers" have a stork with baby picture next to them. The directory is also online at www.CommunityHealthChoice.org > Find a Doctor.

How and when can I switch my baby's Primary Care Provider?
You can switch your baby's Primary Care Provider at any time. Call Member Services to make the change. The change to the new Primary Care Provider will be effective on the first of the next month. A new ID card will be mailed to you.

Can I switch my baby's health plan?
For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker toll-free at 1.800.964.2777. You cannot change health plans while your baby is in the hospital.

How do I sign up my newborn baby?
- The hospital where your baby is born should help you start the Medicaid application process for your baby.
- Check with the hospital social worker before you go home to make sure the application is complete.
- Also, you should call 2-1-1 to find your local HHSC office to make sure your baby's application has been received.
- If you are a Community Health Choice Member when you have the baby, your baby will be enrolled with Community Health Choice on his or her date of birth.

How and when do I tell my health plan?
Call Member Services toll-free at 1.888.435.2850 as soon as your baby is born.

How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?
After your baby is born, you may lose Medicaid coverage. You may be able to get some healthcare services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

How and when do I tell my case worker?
You need to tell your HHSC case worker within 30 days after your baby is born. To get Medicaid benefits and a Medicaid ID Number for your baby, call your case worker right away.

Who do I call if I have special healthcare needs and need someone to help me?
Please contact Member Services for any information on special healthcare needs. You may also contact your Primary Care Provider to assist you in obtaining or learning about services available to you or your baby.

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 yourself.

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 if you need more information.

What do I have to do if I need help with completing my renewal application?

How to Renew https://chipmedicaid.org/CommunityOutreach/How-to-Renew Families must renew their CHIP or Children's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions. The family needs to:

- Look over the information on the renewal application.
- Fix any information that is not correct
- Sign and date the application.
- Look at the health plan options, if Medicaid health plans are available.
- Return the renewal application and documents of proof by the due date.

Once HHSC receives the renewal application and documents of proof, staff checks to see if the children in the family still qualify for their current program or if they qualify for a different program. If a child is referred to another program (Medicaid or CHIP), HHSC sends the family a letter telling them about the referral and then looks to see if the child can get benefits in the other program. If the child qualifies, the coverage in the new program (Medicaid or CHIP) begins the month following the last month of the other program's coverage. During renewal, the family can pick new medical and dental plans by calling the CHIP/Children's Medicaid call center at 1.800.964.2777.

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 doctor?

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

Who do I call?

If you get a bill, call the Provider 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.

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's Member Services Department toll-free at 1.888.435.2850. 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.

When should others pay?

Sometimes, someone other than Community Health Choice should pay for your healthcare. Here is what you need to do to make sure they pay:

When You Have More Than One Health Plan:

You may have another health insurance plan in addition to Community Health Choice. If so, we will make sure the plan pays its fair share. We will also make sure payment for the same health care service occurs only once. The term "Coordination

of Benefits" covers this type of payment. When you go for healthcare, remember that all other health plans must make payments for care before Medicaid can pay. Please let your doctor's office and our Member Services know if another plan covers you.

Coverage through other Government Programs:

If you qualify to receive coverage by veterans' benefits, workers' compensation or Medicare, some of your healthcare will include coverage by them. Please tell our Member Services if you have benefits through any of these programs. We will help you find out when your healthcare includes their coverage.

Starting September 1, 2025, Community Health Choice will pay for some of your current acute care benefits. These are services you already get, and they are being coordinated through Community Health Choice and paid by traditional Medicaid (fee-for-service). Starting September 1, 2025, these services will be paid by Community Health Choice instead of traditional Medicaid (fee-for-service). You will still get your long-term care benefits through Community Health Choice. There are no changes to your Medicare or Medicaid coverage or costs

Illness or Injury Caused by Others:
If you are in an accident, someone else may cover your healthcare. An automobile insurance company might cover you. This could also be true if you get sick because of someone else's action. We need your help to make sure that the other party pays us for the cost of treating you.

Member Rights and Responsibilities

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 healthcare 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 healthcare 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. If your MCO offers In-Lieu-Of Services and Settings, you have the right to:
   a. Be given information about the In-Lieu-Of Services and Settings you can get and how to request them.
   b. Be told why any In-Lieu-Of Services and Settings were reduced or denied.
   c. Choose to refuse to receive In-Lieu-Of Services and Settings instead of other Covered Services.
6. 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 or a State Fair Hearing only from the state Medicaid program and get information about how those processes 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.
7. 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 healthcare 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 healthcare services you can get and how to get them.
8. 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.
9. 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.
10. 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.
11. 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 healthcare 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.

Additional Member Responsibilities while using MTM Health Services

1. When requesting MTM Health Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your MTM Health Services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving Access2Care Services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use MTM Health Services to travel to and from your medical appointments.

7. If you have arranged for MTM Health Services but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

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.

What if I need durable medical equipment (DME) or other products normally found in a pharmacy?

Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all Members, Community Health Choice pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary.

Call Community Health Choice toll-free at 1.888.435.2850 for more information about these benefits.

Complaint Process

What should I do if I have a Complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at 1.888.435.2850 (TTY: toll-free at 7-1-1) 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:

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 send your complaint in an e-mail at hhs.texas.gov/managed-care-help.

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. 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? What are the requirements and time frames for filing a 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.

Appeals

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?

We may deny services if they are not medically necessary. You can request an appeal of a covered or non-covered service orally or in writing. If you request an oral appeal, the oral request will need to be followed by your submission of the one- page Community Medical Appeals Form. You will find the Member Appeal Form in the attachments you received with your denial letter notification from Community Health Choice. Include on the Member Appeal Form the reason you are requesting the appeal in the space provided and the reference number of your denial.

How will I find out if services are denied?

You and your doctor will receive a letter telling you about the denial decision.

What do I need to do to appeal and how much time do I have to do this?

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, including the option to extend up to 14 Days if a Member asks for an extension; 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 does a Member have the right to ask for an Appeal?

You have the right of an appeal for denial of payment for services in whole or in part.

Can I submit my appeal orally?

Yes, can submit your appeal orally or in writing.

You have the option to request an External Medical Review and State Fair Hearing no later than 120 Days after the date Community Health Choice mails the appeal decision notice.

Can I request an extension? Can Community Health Choice request an extension?

Yes. If you request an extension, the time frame may be extended up to 14 calendar days. If Community Health Choice needs an extension, we will tell you the reason for the delay.

When does a Member 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 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 301411
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

What if I'm told I can't get the service I asked for?

If we say no to a service you want—or if we lower, stop, or change the service—you can ask for an appeal. That means you are saying you disagree with our decision and want us to look at it again.

You may ask for an appeal in writing. If you need help in writing your appeal, you can call Community Health Choice Member Services. Send your written appeal to the Medical Appeals Department. Call Community Health Choice Member Services at 1.888.760.2600 or send your appeal to:

Community Health Choice Texas, Inc.
Attention: BH Appeals
P.O. Box 301411
Houston, TX 77230
713.295.2294 or toll-free at 1.888.760. 2600 or TTY 7-1-1
Fax: 713.576.0394/ Attention: BH Appeals Coordinato

When should I submit my appeal to make sure I continue with my current authorized services?

For current authorized services to continue, you must file the appeal on or before the later of:

- 10 calendar days after the date we mail you our notice of the Action
- The date the proposed Action will be effective.
- If you continue to receive services during the Appeals process and the Appeal decision is not in your favor, you may have to pay back the cost of the services you received while the Appeal was pending.

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. Most of the time, we can help you right away or, at the most, within a few days.

Can I ask for a State Fair Hearing?

If you, as a Member of the health plan, disagree with the health plan's decision, you have the right to ask for a State Fair Hearing.

You may name someone to represent you by writing a letter to the health plan telling them the name of 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 letter with the decision. 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

Community Health Choice Texas, Inc.
Medical Appeals Department-Medical Affairs
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
Or call toll-free at 1.888.435.2850.

You have the right to keep getting any service, including an In-Lieu-Of Service and Settings, the health plan denied or reduced, based on previously authorized services, 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 internal appeal decision letter, or (2) the day the health plan's internal appeal decision 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 continue to receive services during the State Fair Hearing process and the State Fair Hearing decision is not in your favor, you may have to pay back the cost of the services you received while the State Fair Hearing was pending.

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.

If you, as a Member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical Provider may be your representative. If you want to challenge a decision made by Community Health Choice, you have the option to request only a State Fair Hearing Review no later than 120 Days after the Community

Health choice mails the appeal decision notice. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing.

To ask for a fair hearing, you or your representative should send a letter to the health plan at:

Community Health Choice Texas, Inc.
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 301411
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

If you ask for a fair hearing, you will get a packet of information letting you know the date, time, and location of the hearing from the State Representative. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

Emergency MCO Appeals

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 time frames for an Emergency Appeal Review?
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 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 decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical Provider may be your representative. If you want to challenge a decision made by Community Health Choice, you have the option to request only a State Fair Hearing Review no later than 120 Days after the Community Health choice mails the appeal decision notice. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should send a letter to the health plan at:

Community Health Choice Texas, Inc.
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 301411
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

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 Information

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling Community Health Choice the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review.

To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to by using the address or fax number at the top of the form;
- Call the Community Health Choice at 713.295.2300 or toll-free at 1.888.435.2850;
- Email Community Health Choice at Appeals@communityhealthchoice.org, or;

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service, including an In-Lieu-Of Service and Settings, the health plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a 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.

The Member can make both of these requests by contacting Community Health Choice at:

Community Health Choice Texas, Inc.
Medical Appeals Department-Medical Affairs
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
or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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 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 are Abuse, Neglect, and 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 another person for personal or monetary gain. 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 Health and Human Services (HHSC) by calling 1.800.458.9858 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 Fraud, Waste or Abuse?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare Providers or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste or abuse, 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 Fraud, Waste or Abuse, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184;
- Visit https://oig.hhsc.state.tx.us/. Under the box labeled "I WANT TO," click "Report Fraud, Waste or Abuse" to complete the online form; or
- You can report directly to your health plan:

Community Health Choice Texas, Inc.
Chief Compliance Officer or Director SIU
4888 Loop Central Drive, Suite. 600
Houston, TX 77081
Toll-free at 1.877.888.0002

To report Fraud, Waste or Abuse, 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 fraud, waste or abuse

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 after hours and emergency coverage and limits to those kinds of benefits, including:
  - o What makes up Emergency Medical Conditions, Emergency Services, and Post-Stabilization Services.
  - o The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - o How to get Emergency Services, including instructions on how to use the 911 telephone system or its local equivalent.
  - o 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 Choice's practice guidelines.

Privacy Notice

Notice of Privacy Practices
Effective: April 14, 2003
Updated: December 2017
Last Review Date: September 2022

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

This Notice of Privacy Practices is given to you as part of the Health Insurance Portability and Accountability Act (HIPAA). It says how we can use or share your protected health information (PHI) and sensitive personal information (SPI). It tells you who we can share it with and how we keep it safe. It tells you how to get a copy of or edit your information. It ensures that any oral, written, and electronic information you share with us is confidential and secure. You can allow or not allow us to share specific details unless needed by law.

Our Responsibility To You Regarding Protected Health Information

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

By law, Community must:

- Make sure that your PHI/SPI is kept private.
- Give you this notice of our legal duties and privacy practices. It describes the use and disclosure of your PHI/SPI.

Follow the terms of the notice in effect now.

- Tell you about any changes in the notice.
- Notify you that your health information (PHI/SPI) created or received by Community is subject to electronic disclosure.
- Give you an electronic copy of your record within 15 days after you ask in writing. We can also give this to you another way if you ask for it. There are some exceptions to this rule.
- With exceptions, not sell any PHI/SPI.
- Disclose any breach of unencrypted PHI/SPI we think an unauthorized person might have.
- Train employees about our privacy practices. Training is no later than 60 days after their first day and at least every two years after.

We have the right to change this notice. The effective date is on the bottom of each page. You can get a copy from our Web site: www.CommunityHealthChoice.org. You can also call our Member Services toll-free at 1.888.435.2850 and ask for a copy to be mailed to you.

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

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

Treatment — Community will use and share your PHI/SPI to provide, coordinate or manage your health care and other services. We might share it with doctors or others who help with your care. In emergencies, we will use and share it to get you the care you need. We will only share what is needed.

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

Health Care Operations — We can use or share your PHI/SPI in our daily activities. For example:

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

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

Required by Law — By law, sometimes we must use or share your PHI/SPI. Here are some examples:

Public Health Authorities

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

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

Health Oversight Agencies and U.S. Food and Drug Administration — We will share your PHI/SPI when health oversight agencies ask for it.

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

Law Enforcement and Criminal Activity — We will share your PHI/SPI if we believe it helps solve a crime. We will share it to stop or reduce a serious threat. We can also share it to help law enforcement officers find or arrest a person.

Coroners, Funeral Directors, and Organ Donations — We share PHI/SPI with coroners, medical examiners, and funeral directors. We can also share it to help manage organ, eye or tissue donations.

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

Military Activity and National Security — We can share PHI/SPI of Armed Forces personnel with the government.

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

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

Disclosures by the Health Plan — We will share your PHI/SPI to get proof that you are able to get health care. We will work with other health insurance plans and other government programs.

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

For People Involved in Your Care or Payment for Your Care — We will share your PHI/SPI with your family or other people you want to know about your care. You can tell us who is allowed or not allowed to know about your care. You must fill out a form that will be part of your medical record.

Restrictions on Marketing — The HITECH Act does not let Community receive any money for marketing communications.

Other Laws that Protect Health Information — Other laws protect PHI/SPI about mental health, alcohol and drug abuse treatment, genetic testing and HIV/AIDS testing or treatment. You must agree in writing to share this kind of PHI/SPI.

Your Privacy Rights With Respect to Your Health Information

Right to Inspect and Copy Your Health Information — In most cases, you have the right to look at your PHI/SPI. You can get a printed copy of the record we have about you. It can also be given to you in electronic form. There might be a charge for copying and mailing.

Right to Amend Your Health Information — You can ask Community to change facts if you think they are wrong or not complete. You must do this in writing. We do not have to make the changes. If we deny your request, we will do so within 60 days.

Right to an Accounting of Disclosures — You can ask for a list of certain disclosures of your PHI/SPI. The list will not include PHI/SPI shared before April 14, 2003. You cannot ask for more than six years. The list can only go back three years for electronic PHI/SPI. There are other limits that apply to this list. You might have to pay for more than one list a year.

Right to Ask For Restrictions — You can ask us to not use or share part of your PHI/SPI for treatment, payment or health care operations. You must ask in writing. You must tell us (1) the PHI/SPI you want restricted; (2) if you want to change our use and/ or disclosure; (3) who it applies to (e.g., to your spouse); and (4) expiration date.

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

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

Right to Receive Confidential Communications — You can tell us where and how to give you your PHI/SPI. You can ask us to only call at a certain number. You can also give us another address if you think sending mail to your usual address will put you in danger. You must be specific and put this in writing.

Right to Choose Someone to Act for You — If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has this authority and can act for you before we take any action.

Right to a Copy of this Notice — You can ask for and get a copy of this notice at any time, even if you have received this notice previously or agreed to receive this notice electronically.

Right to Withdraw an Authorization for Disclosure — If you have let us use or share your PHI/SPI, you can change your mind at any time. You must tell us in writing. In some cases, we might have already used or shared it.

Right to be Notified of Breach — You will be told if we find a breach of unsecured PHI/SPI. The breach could be from either Community or a Business Associate of Community.

Federal Privacy Laws

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

Complaints

You can file a complaint if you believe your privacy rights have been violated. You can call Community's Privacy Officer toll-free at 1.888.435.2850. You can also file a complaint with the Department of Health and Human Services, Office of Civil Rights. Please refer to the Office of Civil Rights contact information at the end of this notice. We urge you to tell us about any privacy concerns. You will not be retaliated against in any way for filing a complaint.

Authorization to Use or Disclose Health Information

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

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

Effective Date

This notice took effect on April 14, 2003, and was updated on December 2017. It was last reviewed in September 2022.
It will stay in effect until it is replaced by another notice.

Contact Information

If you have any questions or complaints:

Community Health Choice Texas, Inc.
Chief Compliance Officer
4888 Loop Central Drive, Suite. 600
Houston, TX 77081
Toll-free at 1.877.888.0002

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W. Room 509F HHH Building
Washington, D.C. 20201
Phone: 1.877.696.6775
www.hhs.gov/ocr/privacy/hipaa/complaints

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

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
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 TTY 7-1-1

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

NON-DISCRIMINATION STATEMENT CHIP/STAR

Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. 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 Health Choice, Inc. Member Services Department at 1.888.760.2600. If you believe that Community Health Choice, Inc. 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
2636 South Loop West, Suite 125
Houston, TX 77054

Phone: 1.888.760.2600
E-mail: ServiceImprovement@CommunityHealthChoice.org
Fax: 713.295.7036

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)

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2636 South Loop West, Suite 125
Houston, TX 77054

Phone: 1.888.760.2600
E-mail: 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

Member Events

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








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COMMUNITY
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