AND D

CommunityHealthChoice.org
713.295.6704 | 1.855.315.5386

IMPORTANT PHONE NUMBERS

1.855.315.5386

MEMBER SERVICES
8:00 a.m. – 5:00 p.m., Monday – Friday,
(excluding federal-approved holidays.)

PROVIDER SERVICES
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713.295.6704

Infor

7-1-1

1.800.835.2362

1.866.646.6963

1.866.333.2757

Navitus.com

1.800.552.6694

Ppsrx.com (Kroger Mail Order)

1.844.293.1752

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1.855.539.5881

CommunityHealthChoice.org

1.877.888.0002

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Member Handbook

This handbook is a guide to help you get the health care you need and is a companion piece to the Evidence of Coverage
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are online at www.CommunityHealthChoice.org and can be mailed to you upon request. Contact Community Member Services at 713.295.6704, Toll-free at 1.855.315.5386, or email MemberServices@CommunityHealthChoice.org.

Evidence of Coverage

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

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>LœÕÌ …i>•Ì… «•>˜ Li˜iwÌÃ >˜` VœÛiÀ>}i ˆ˜ > ÈӍ«•i Ü>Þ° /…ˆÃ
document will help you better understand your coverage and allow you to easily compare different coverage options. It

Covered healthcare expenses must be considered medically necessary

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

If you need emergency care:

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

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

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

An urgent problem is when you are sick or hurt and need treatment right away to keep you from getting worse. If your
proeed -1.111 Td [(women, this1F]TJ 0 - L ar)F.eH8eCn -1.- Mdi..- Mdi82T96

LIMITATIONS AND PREFERRED DRUG LIST

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

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

4HESE LIMITATIONS AND EXCLUSIONS APPLY
OR 0ROVIDER HAS PERFORMED OR PRESCRI
APPROPRIATE SERVICE This does not prevent your Provid
providing or performing the service; however, it will not be a covered service that we pay for.

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- Services provided by a non-network Provider, except when authorized or for emergency services
- Services incurred before or after coverage begins or ends
- Services that are not medically necessary
- Charges for prophylactic services
- Services that are experimental or investigational
- Services relating to an illness or injury incurred as a result of ì…i Vœ Ûi Ài` «iÀÃœ˜ Li˜} ˆ˜ÌœÝˆV>Ìi` œÀ Õ˜`iÀ Ì…i ˆ˜vÕi˜Vi of illegal narcotics or a controlled substance
- Services relating to illness or injury to the body incurred as a ÀiÃÕ•Ì œv ˆ˜Ìi˜Ìˆœ˜>••Þ Ãi•v‡ˆ˜y•ˆVÌi` Lœ`ˆ•Þ …>À“] Ü>À] œÀ >˜ >VÌ of war, taking part in a riot, engaging in an illegal occupation, >˜Þ >VÌ œv >À“i` Vœ˜y•ˆVÌ] œÀ >˜Þ Vœ˜y•ˆVÌ
forces or any authority
- Cosmetic services or any complication resulting from cosmetic services except as described in the Evidence of Coverage
- Custodial care and maintenance care
- Ambulance services for routine transportation to, from, or between medical facilities and/or a healthcare practitioner's œvwVi
- Infertility treatment
- Reversal sterilization
- Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other surgery or procedure to correct myopia, hyperopia, or stigmatic error; orthoptic treatment -iÞi iÝiÀVˆÃiÃ®Æ œÀ Ì…i «ÕÀV…>Ãi œÀ wÌ̈˜} œv iÞi}•>ÃÃiÃ œÀ Vœ˜Ì>VÌ •i˜ÃiÃ Õ˜•iÃÃ Ã«iVˆwi` ˆ˜ Ì…ˆÃ Vœ˜ÌÀ>VÌ
- Dental services
- Any treatment for obesity or complications related to such treatment.
- Foot-care services in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous ˆ˜ÃÕvwVˆi˜VÞ
- Hair prosthesis, hair transplants, or hair implants
- Hearing care, except as expressly provided in the Evidence of Coverage
- Over-the-counter medical items or supplies
- Immunizations including those required for foreign travel except as provided in the Evidence of Coverage
- Treatment for any jaw joint problem
- Genetic testing or services
- Services received in an emergency room, unless emergency care
- Any expense incurred for services received outside of the United States, except for emergency care services
- Charges for alternative medicine
- Private-duty nursing, except inpatient private-duty nursing when Medically Necessary).
- Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement

PRIOR AUTHORIZATION

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Prior authorization means Community reviews proposed services and prescription drugs to determine if they are medically necessary before they are provided. We require prior authorization for certain services and prescription drugs.

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

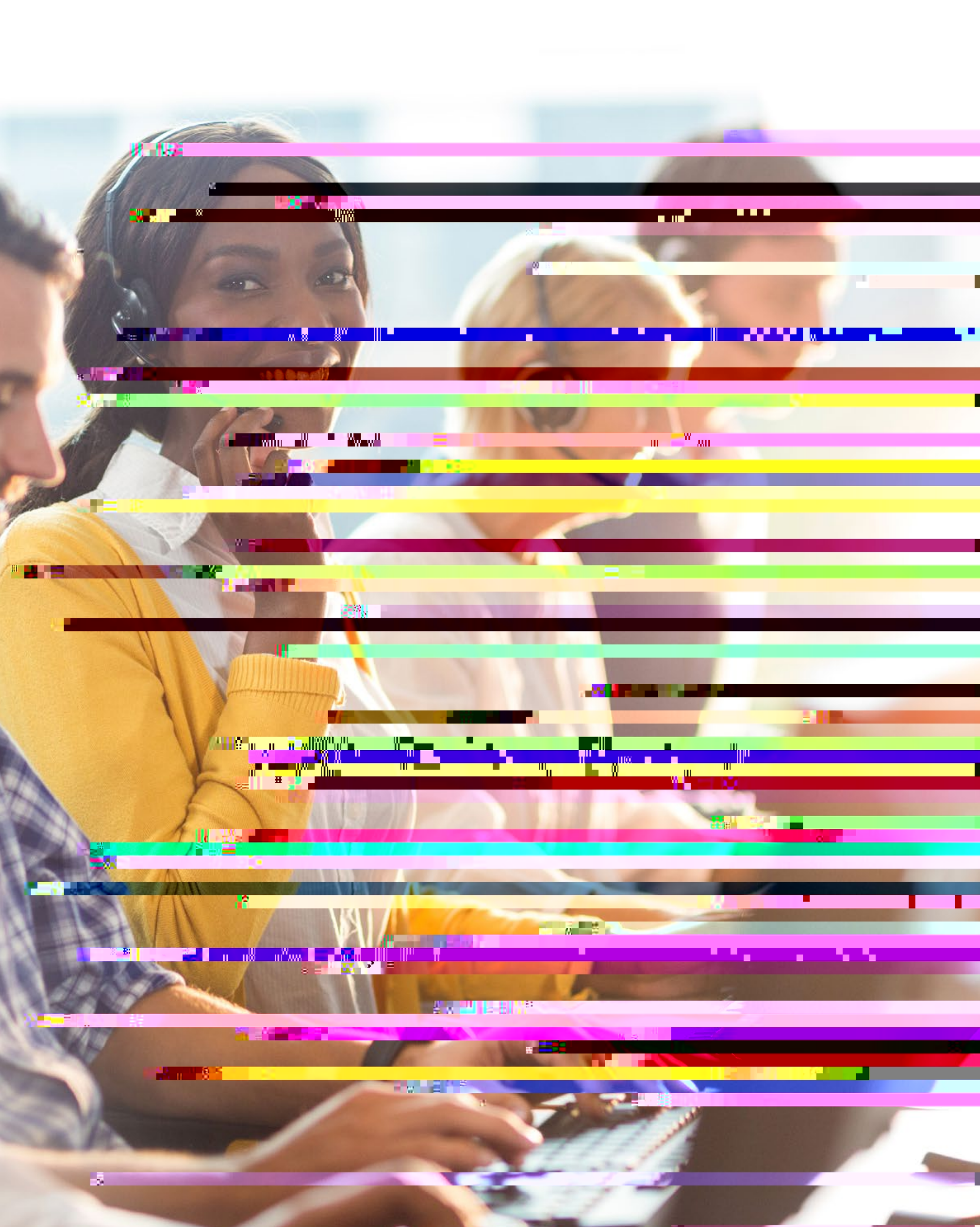
Services and prescription drugs that do or do not require prior authorization are subject to change. We have a list of services that require prior authorization and a prescription drug formulary that tells you when prior authorization is required for prescription drugs. To obtain a list, go to www.CommunityHealthChoice.org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

You are responsible for informing your physician or Provider about our prior authorization requirements. Your physician or Provider must contact us by telephone, electronically, or in writing to request the appropriate authorization. The telephone number to call to request authorization is on Þ œ Õ À i “ L i À `i ˜ Ì ˆ w V > Ì ˆ œ ˜ > À ` ° œ L i ˜ i w Ì Ã > À i « > Þ > L • i v œ À Ã i À Û ˆ V i Ã œ À prescription drugs that are not-covered services.

We will issue a determination on a request for prior authorization no later than three (3) calendar days of receiving the request. If the prior authorization involves a concurrent hospital care, We will issue a determination within twenty-four (24) hours of receiving the request. If the prior authorization involves post-stabilization treatment or a life-threatening condition, We will issue a determination within the timeframe appropriate for the circumstances relating to the delivery of the services and conditions of the enrollee, but in no case to exceed one hour from receipt of the request.

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

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



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APPEALS

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An adverse determination is a determination made by Community that the healthcare services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. You have the right to appeal an adverse determination. You, your Provider, or someone else you choose as your representative may also appeal. You have one hundred eighty (180) days from the date

NETWORK PROVIDERS

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Search our online directory of Network Providers at www.CommunityHealthChoice.org. Our online directory is updated in real time. Please check the online directory before you obtain services to ensure that the Provider is1 -0.653 2.c9e18c-0 0 (ovw 1 -0.653 2.c9eWhe obtm [(Sear)ing,ect to ensur)1oobtlrovw 1 -0.c

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MARKETPLACE SERVICE AREAS

USING YOUR BENEFITS

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To create a Member account:

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

YOUR COMMUNITY CARE MEMBER ID CARD

How to use your benefits

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

Helpful numbers

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

USING YOUR BENEFITS

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You should not receive a bill from a Network Provider for a covered service. If you do, call Community Member Services for help at 713.295.6704, Toll-free at 1.855.315.5386, or email MemberServices@CommunityHealthChoice.org. You may be required to submit a copy of the itemized billing statement and a copy of your Member ID card. Please be sure to provide your `œVÌœÀ½Ã œvwVi Ü ˆÌ… Þœ ÕÀ ˆ˜ÃÕÀ>˜Vi ˆ˜vœÀ“>Ì ˆœ˜ «À ˆœÀ Ìœ V>••ˆ˜} Community Health Choice.

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You may change your PCP through your My Member Account at www.CommunityHealthChoice.org. You may also change your PCP by calling Member Services at 713.295.6704 or Toll- free at 1.855.315.5386. The effective date of the PCP change is on the wÀÃÌ œv Ì…i vœ••œÜˆ˜} “œ˜Ì…°

In the meantime, your current PCP will continue to coordinate your care. You must arrange to have your or your dependent's “i`ˆV>• w•iÃ ÌÀ>˜ÃviÀÀi` Ìœ Ì…i ˜iÜ * *°

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

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

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

All medical needs should be discussed with the PCP. Although we allow open access to specialty care physicians without a referral from a PCP or authorization from us, some specialty care physicians will require a referral from your PCP. If you and your PCP determine that there is a need to see a specialty care «…ÞÃ^V^>˜] Ì…i * * V>˜ ÀiVœ““i˜` œ˜i Ã«iV^>w V ^Ìœ ÞœÕÀ ˜i`^V>• needs.

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

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

1. In accordance with nationally recognized standards of “i`^V>• «À>VÌ^Vi >˜` ^`i˜Ì^wi` >Ã Ã>vi] Ü^`i• generally accepted as effective for the proposed use;
2. Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
3. Not primarily for the convenience of the patient or healthcare practitioner;
4. Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
5. Performed in the most cost-effective setting required by the patient's condition;
6. Supported by the preponderance of nationally recognized, peer-reviewed medical literature, if any, published in the English language as of the date of service; and
7. Not experimental, investigational, or for research purposes.

Marital
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Telephone
Office Address
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Mother

FRAUD AND ABUSE

NOTICE OF PRIVACY PRACTICES

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

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

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

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

If we think it is not best for those involved, or cannot limit the records, we do not have to agree. If we agree, we will only share h/SPI in writinthe changes. If we deny yopurphesply tomI/SP( )]TJ 0stin( )]Tould neYthiharent, or

FREQUENTLY ASKED QUESTIONS

Enrollment in Community’s Marketplace plans is only allowed

MEMBER SATISFACTION SURVEY

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

THANK YOU

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

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