Chapter 2: Member Eligibility & Member Services

Health Choice Insurance Co. Member Services Department

Our members and their medical care are very important to us. To ensure their needs are met, the Health Choice Insurance Co. (Health Choice) Member Services Department coordinates all membership activities. The primary functions of the Member Service Department include:

- Verification of member eligibility
- Primary care physician (PCP) assignment and changes
- General health plan questions
- Immediate member issue resolution; referrals of other issues (grievances/complaints) to the Quality Management department for further investigation and resolution.
- Arranging translation services including hearing impaired and sign language
- Conducting member satisfaction surveys
- Health Risk Assessments

The Health Choice Member Services department is available from 8:00 AM to 6:00 PM, Monday through Friday at 1-855 452-4242.

Eligibility

Health Choice offers family, individual and child-only plans to eligible enrollees (members). Enrollees have the right to select their health plan through the Health Insurance Marketplace (Marketplace) or directly from Health Choice during the annual open enrollment period or via a special enrollment period, if they have a qualified life event.

Health Insurance Marketplace Copayments, Deductibles and Coinsurance

Please ask to see the member's ID card. Deductible, copayment and/or coinsurance apply for covered services as outlined in the Schedule of Benefits for the plan the member selected at the time of enrollment.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for covered services each calendar year (January through December) before the benefit plan begins to pay for covered services. The deductible applies to every covered service unless the schedule of benefit for the plan the member enrolled in says it does not apply.

Each individual member has a calendar-year deductible. If the member has family coverage, there is also a calendar year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also

count toward any family deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members.

The deductible is based on the allowed amount.

Amounts paid for copayments do not count toward the deductible.

Copayment

A copayment is a specific dollar amount the member must pay to the provider for some covered services. If a copayment applies to a covered service the member must pay it when they receive services. There may be different copayments for various covered services. If a copayment does not apply to a service, the member pays the applicable deductible and coinsurance, unless otherwise specified within the benefit provision.

Coinsurance

Coinsurance is a percentage of the allowed amount that the member pays for covered services after meeting any applicable deductible. Coinsurance applies to every covered service unless the Schedule of Benefits applicable to the plan the member selected says it does not apply.

Health Choice normally calculates coinsurance based on the allowed amount. There is one exception. If a hospital provider's billed charges are less than the hospital's reimbursement, Health Choice will calculate coinsurance based on the lesser billed charge.

Out-of-Pocket Maximum

Out-of-pocket maximum is the amount an individual member must pay each calendar year before Health Choice Insurance Co. begins paying 100 percent of the allowed amount of covered services, for the remainder of the calendar year. The member is still responsible for other types of cost share payments, even after the member has met their out-of-pocket maximum.

The payments listed below do not count toward the out-of-pocket maximum. Other than the deductible, which must be met before coinsurance applies; the member must keep paying the following even after the member has met their out-of-pocket maximum:

- Amounts above a benefit maximum without prior authorization
- Any amounts for balance billing
- Any amounts for non-covered services
- Any charges for lack of prior authorization

Cost Sharing Obligations

Health Choice uses claims to track whether the member has met some or all of their cost sharing obligations. We apply claims based on the order in which we process the claims and not based on the date of service.

Health Choice Insurance Co. ID Card

Each eligible member receive an identification card that indicates the member's name, the member's identification number and health plan chosen by the member. The Health Choice Insurance Co. identification card does not guarantee eligibility. (See Exhibit 2.1 Maricopa Co and Exhibit 2.2 Non- Maricopa Co ID Card).

Providers should request the member's identification card at the time of visit. Services cannot be denied if the member does not have their ID card at the time of the appointment. Health Choice recommends you ask for a second form of identification for members not known to you.

If a member has lost their card, please direct them to call Member Services at 1-855-452-4242.

Members need to tell the Marketplace (or us if the member enrolled directly with Health Choice) about changes such as individuals being added to the benefit plan, alternate insurance coverage, address or phone number changes, other coverage that the member or their dependent's may add or lose, individuals removed from the dependent plan due to divorce or death, disability status of dependents.

Primary Care Physician (PCP)

Health Choice Insurance Co. contracts with General Practice, Family Practice, Internal Medicine, and Pediatric physicians to provide PCP services to enrolled Health Choice Insurance Co. members. Health Choice does require members to choose a PCP.

Health Choice offers its members the freedom of choice in selecting a PCP within its network. There are instances when Health Choice may restrict a member's choice of PCP. Examples include, but are not limited to, when a member frequently changes their PCP, for medically necessary reasons or due to location to members' residence.

Each new member enrolled with Health Choice Insurance Co. receives written notification of their PCP by mail. In addition to the letter with the PCP information, an Evidence of Coverage (EOC) is provided that outlines the Member's Rights and Responsibilities. The EOC is a resource that provides assistance for members on how to obtain health care services through Health Choice Insurance Co.

Pediatricians and OB/GYNs

Network pediatricians can be chosen as a PCE for a dependent child/member.

Female members may see a network obstetrician/gynecologist (OB/GYN) at any time, without a referral from a PCP (PCO) during the course of their pregnancy.

Newly Adopted and Newborn

Adopted Child

Coverage under Health Choice plans for newly adopted child will become effective from the date of Placement for the purpose of adoption and will continue for 31 days unless:

- Placement is disrupted prior to legal adoption; or
- The child is removed from Placement.

"Placement" means the transfer of physical custody of a child who is legally free for adoption to a person who intends to adopt the child.

In order for the newly adopted child to be insured under this plan, the subscriber must, within thirty (30) days of acquiring the newly adopted child, provide Health Choice Insurance Co. with the following:

- Written notification of the placement of the adopted child; and
- Payment of any additional premium required for the adopted child's coverage under this plan to continue beyond the initial thirty-one (31) day period.

Newborn Child

Coverage under this plan will be provided for each newborn child of a member from the moment of birth for thirty-one (31) days. The member must give us:

- Written notification of the birth of the child; and
- Payment of any additional premium required for the adopted child's coverage under this plan to continue beyond the initial thirty-one (31) day period.

Newborns receive separate Health Choice Insurance Co. ID cards and services for them must be billed separately using the newborn's ID. Services for a newborn that are included on the mother's claim will be denied.

PCP/PCO Assignment Change

Providers may request a member be removed from his/her roster. This must be submitted in writing and signed by the physician, the provider must provide emergency services for a period of thirty (30) days from the notice or until the member is assigned and able to establish with a new PCP, whichever comes first. A copy of the notice needs to be provided to the

member and Health Choice Insurance Co. Rather than remove these members from your roster; we prefer to collaborate with you in managing their health care. Depending on the issue, Health Choice will either contact the member directly or coordinate with our Case Management Department in an attempt to resolve the issue. It is important for your office to continue providing care to the member during this process. If no improvement is achieved after our interventions, it may be agreed that the member needs a new primary care physician. Member removal from your roster should be considered as a last resort.

Member assignment changes are effective the first of the month following notification. You can fax both provider and member letters to 480- 760-4708, Attention Member Services.

Involuntary Disenrollment

Health Choice Insurance Co. may remove (disenroll) members from a provider's roster. Some reason for removal might include:

- If the member is abusive, threatening or act violent
- If member does not follow medical advice or does not keep a good relationship with their physician
- If the member allows someone else to use their Health Insurance Co. ID card
- If the member does not pay premiums

Patient's Bill of Rights

- The Affordable Care Act puts consumers in charge of their health care. Under the law, a new "Patient's Bill of Rights" gives the American people the stability and flexibility they need to make informed choices about their health.
- Provides coverage to Americans with pre-existing conditions
- Protects their choice of doctors: The primary care physician from the plan's network.
- Keeps young adults covered until the end of the month the member turns 26.
- Ends lifetime limits on coverage: Lifetime limits on essential health benefits are banned for all health insurance plans.
- Ends pre-existing condition exclusions: Health plans can no longer limit or deny benefits due to a pre-existing condition.
- Ends arbitrary withdrawals of insurance coverage: Insurers can no longer cancel coverage just because of make an honest mistake.
- Reviews premium increases: Insurance companies must now publicly justify any unreasonable rate hike.
- Helps you get the most from premium dollars: Premium dollars must be spent primarily on health care – not administrative costs.

- Removes insurance company barriers to emergency services: Members seek emergency care at a hospital outside of the plan's network.

The Health Care Law

- Covers preventive care at no cost to the member
- Guarantees a member's right to appeal: Members have the right to ask that the plan reconsider its denial of payment.

Member Rights and Responsibilities

- Be treated with respect and dignity.
- Have health information kept private, unless allowed by law.
- Get medical care without being treated unfairly – this means that Health Choice Insurance Co. and providers treat all members with respect. It means that all members have equal access to all Health Choice Insurance Co. services. This includes the way the member is spoken to and treated. Health Choice Insurance Co. and its providers do not discriminate against any member on the basis of race, color, national origin, disability, sex, religion or age.
- Have services and materials provided in a way that helps the member understand. These may include help with having information translated into another language. We have providers who speak languages other than English. If you need information in another language, please let us know.
- Choose a PCP and other providers from the Health Choice Insurance Co. network list.
- Members have the right to make decisions about their healthcare. This includes agreeing to treatment, the right to refuse treatment and the right to a second opinion.
- Be free from any form of control or isolation used as a means of force, authority, convenience, or retaliation. Members can rate a plan that tells health care providers what kind of treatment they do or do not want if they become too sick to make their own health care decisions.
- Obtain information about grievances, appeals and requests for a hearing.
- Members have the right to complain about Health Choice Insurance Co. and cannot be denied services if a complaint is filed.
- Request to see their medical records and request that they be amended or corrected.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Be furnished health care services in accordance with access to care and quality standards.

If a member feels they have been treated unfairly for any reason, they may call Member Services and ask to speak with Health Choice Insurance Co.'s Grievance Coordinator to report it.

Member Responsibilities

A Health Choice Insurance Co. member had the responsibility to:

- Know the name of their Primary Care Provider (PCP), tell the doctor about their health history and include any medical problems or concerns. This will help your doctor give the best possible care.
- Follow the health care provider (doctor) advice. This includes:
  - Taking medicine as ordered by your doctor
  - Talking with the doctor about their medical care
- Make sure the doctor submits referrals to specialists and gets prior approval for services when needed.
- Make appointments during office hours when possible, and not use urgent care centers or emergency rooms for routine care.
- Get to appointments on time. Call the doctor ahead of time if unable to make an appointment. Arrive at the office early if seeing the doctor for the first time.
- Bring records of children's shots to every appointment for children. This includes all members who are 18 years of age or younger.

This chapter is intended to provide an overview of the member's coverage. Please refer to the Evidence of Coverage (EOC) for all details concerning eligibility, benefits, and cost sharing obligations.