

MEMBERSHIP AND ELIGIBILITY

Section III

I. MEMBER RIGHTS AND RESPONSIBILITIES

Community Health Plan is dedicated to providing quality healthcare to our members. Our designated Customer Service Representatives assist members with questions about benefits, providers, etc. Each of our members has rights and responsibilities that facilitate optimal care and treatment of their illnesses/injuries. The following is a list of Member Rights and Responsibilities:

MEMBER RIGHTS

- A right to receive information about Community Health Plan, its services, its practitioners and providers and members' rights and responsibilities
- A right to be treated with respect and recognition of their dignity and their right to privacy
- A right to participate with practitioners in decisions about their health care
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- A right to voice complaints or appeals about Community Health Plan or the care it provides
- A right to make recommendations regarding Community Health Plan's members' rights and responsibilities policies

MEMBER RESPONSIBILITIES

- A responsibility to supply information (to the extent possible) that Community Health Plan and its practitioners and providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed on with their practitioners
- A responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible

II. ENROLLMENT PROCEDURES

Community Gold, Community Choice, Community POS

Members covered under these HMO products must select a Primary Care Provider from Community Health Plan's list of participating Primary Care Providers. Members of the same family also may individually choose a Primary Care Provider within the Community Health Plan Network. Primary Care Providers are defined as general and family practitioners, internists, pediatricians, nurse practitioners and physician assistants.

Each subscriber must complete an Enrollment Form with information on each dependent. An effective date of coverage will be assigned for each new member. The Primary Care Provider will be issued an Eligibility Report at the beginning of every month listing the names and effective dates of all members assigned to their practice.

Kansas POS-2

Members covered under the Kansas POS 2 product do not need to select a Primary Care Provider.

Please contact our Customer Service Representatives if you have any questions regarding member eligibility.

Community Health Plan (816) 271-1247 or 1-800-990-9247

III. MEMBER IDENTIFICATION CARDS

Upon enrolling in Community Health Plan, each member will receive an Identification Card that includes his/her identification number and designated co-payments. The member's Identification Card does not guarantee eligibility since a member can disenroll from Community Health Plan and retain the card.

When a member visits your office, ask to see their most recent Community Health Plan Member Identification Card, make a copy of it for the member's medical record and check the monthly Eligibility Report to verify membership. All additions should be recorded on the monthly Eligibility Report.

An office visit copayment amount will be noted on the front of the Member Identification Card. Copayments may vary or change upon a group's renewal of contract by an employer group. Always check the Member Identification Card against the Eligibility Report.

Occasionally, a newly enrolled member may seek service before receiving a Member Identification Card or before the Eligibility Report is issued. To verify eligibility refer to the MyCHP Service program online at www.mychp.com or contact our Customer Service Department.

In order to foster good member relationships, Community Health Plan requests that the Primary Care Provider provide services to any newly enrolled member even though the member has not presented an Identification Card. Membership can be verified by viewing a copy of the individual's completed enrollment form. Make sure your name (the PCP) is printed under Primary Care Provider in the instance that an individual presents with an enrollment form.

An example of the Community Health Plan member identification card can be found on the following page.



www.mychp.com

Member #
Effective Date

Member Name
Group
Group Number
Product Type **Fully-Insured Plan (HMO)**
PCP Name

COPAYS: OV: \$15/25 UC: \$25
ER: \$75

PHARMACARE: BIN 610468 PCN COMHP

COMMUNITY HEALTH PLAN

Heartland Health Business Plaza 137 N. Belt St. Joseph, MO 64506

CUSTOMER SERVICE: 816-271-1271 OR 800-990-9247

24-HOUR HEALTH ADVICE: 816-271-4000 OR 800-455-2476

Pharmacare Customer Service 1-800-777-1023

Members are responsible for copayments, deductibles and co-insurance

Provider's Note:

Telephone Referral or Pre Authorization
1-800-447-5819 or (816) 271-4019



www.mychp.com

Member # 07110013604
Effective Date 12/01/07

Member Name
Group
Group Number
Product Type: **Self-Funded (ERISA) Plan**
PCP Name

COPAYS: OV: \$20/40 UC: \$50
ER: \$150

PHARMACARE: BIN 610468 PCN.COMHP

COMMUNITY HEALTH PLAN

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Members are responsible for copayments, deductibles and co-insurance

Provider's Note:

Telephone Referral or Pre Authorization
1-800-447-5819 or (816) 271-4019

IV. ELIGIBILITY REPORT

At the beginning of each month Primary Care Providers will receive the monthly Eligibility Report, which is a list of eligible members who have selected their office for Primary Care. At the time a member seeks service, check member eligibility against the Eligibility Report. It is not necessary to call Community Health Plan if the member's name appears on this report. Verification of member eligibility is also available in the My CHP Service program at www.mychp.com.

If a Community Health Plan member seeks service and is not on your Eligibility Report or if you do not have an Eligibility Report, please call our Customer Service Department at (816) 271-1247 or 1-800-990-9247. From time to time, a Customer Service Representative may call your office to inform you that a member's name should be included on your list. The member's name should then be handwritten on your list.

The Customer Service Representative will also provide you with the details of the member's benefits, such as the co-payment amount.

V. MEMBER CONCERNS AND INQUIRIES

An important part of Community Health Plan's program is the mechanism through which members can ask questions and resolve problems that may arise. It is to the advantage of all concerned if a question can be answered quickly and a problem can be solved promptly, fairly and informally. Often, members will address their concerns directly to the Primary Care Provider and a resolution will be found without Community Health Plan's intervention.

In the event that a question or problem cannot be resolved by the Primary Care Provider, members should be instructed to contact the Customer Service Department of Community Health Plan.

If the Customer Service Department cannot informally resolve the problem, the appeals process is available to the member.

If a member complaint involves a participating provider or office, it is Community Health Plan's policy to notify those individuals involved of such a complaint. A formal process will be followed as outlined in Community Health Plan's Utilization/Quality Management Plan.

VI. PRIMARY CARE PROVIDER CHANGES

In the event that a Community Health Plan Member wishes to select a new Primary Care Provider, the member may contact the Customer Service Department. Members (in most cases) may change their PCP by using the interactive online program MyCHP Service on our CHP web site, www.mychp.com. Members of several of our employer groups require their employees to contact their Human Resources Department to change their Primary Care Provider.

Community Health Plan does accept Primary Care Provider changes from the member, or the parent if the member is a minor. If a member is at the provider's office and wants to change Primary Care Providers, please ask the member to call the Customer Service Department directly.

VII. REQUESTS TO DISCHARGE A MEMBER

The Primary Care Provider may discharge a member from care after obtaining Community Health Plan's approval. A letter stating the reasons for wanting to discharge the member must be sent to the Provider Relations Department. After approving the request, Community Health Plan will provide written notice to the member and will send a copy of the notice to the Provider. Such notice may take at least 15 to 45 days to notify the member, depending on the time it will take our Customer Service Department to contact the member and for that member to select another Primary Care Provider. During this time, the current provider is obligated to provide covered services for the member until the change is completed.

It must be emphasized that a Primary Care Provider's request to have a member choose another Primary Care Provider should be based upon unmanageable personality differences or related conflicts and not on patterns of utilization or diagnosis. The provider should make every effort to educate the member regarding potential benefit abuse, but if a member habitually abuses benefits, the Primary Care Provider should notify the Provider Relations Representative so that appropriate action can be taken regarding that member.