
HEALTH
INSURANCE
MARKETPLACE
2024 BROKER TRAINING
COMMUNITY
HEALTH CHOICE
COMMUNITY CARES.

HOUSEKEEPING

- Be respectful of your peers: Please make sure you are on mute during the webinar and hold questions to the end of the presentation
- Presentation will be sent to all agents via email
- 2024 agency/agent paperwork is available for non-appointed agents/agencies, but should be completed and submitted immediately to ensure timely appointment (Commissions will not be paid on any business sold prior to appointment confirmation)
- Please be sure to provide any updates to your W9/Addresses/Contact Information, i.e., phone, email, etc.

AGENDA

- Broker Appointment & Agreement Reminders
- Billing, Payment and Enrollment
- 2024 Plans, Benefits & Rates
- Service Area and Network
- Enrollment & SEP's
- Next Steps
- Q&A

BROKER APPOINTMENT & AGREEMENT REMINDERS

BROKER APPOINTMENT

- Must complete annual CMS certification for Individual Marketplace
- Must complete annual Community training and pass quiz with a score of 80% or higher
- All agents must complete and return a Broker Training Attestation form
- Must have an active TDI license
- Must hold an active Errors & Omissions Policy
- Must supply a W9 that corresponds to tax filing address (If a sub-agent of an Agency, a W9 is not required as we will utilize Agency W9

Broker Appointment-
Error and Omissions Policy

- For our Agency Partners- Community Health Choice will accept individual agent E & O coverage for your downline/sub-agents
- Community does not require that you carry all sub-agents on your Agency E & O coverage while they are contracted with your Agency
- **Independent Agents and Agency sub-agents -** acceptable E & O must meet the following criteria:
  - The Agent/Sub-Agent E & O policy must be in their name. If an LLC, the policy must reference the Agent/Sub-Agent name
  - If E&O is provided by the Agency, the sub-agent name on the E & O policy must match the name as they are appointed with Community Health Choice
  - The E & O policy must maintain an Errors and Omissions Insurance in an amount of not less than one million dollars ($1,000,000) per occurrence and one million dollars ($1,000,000) annual aggregate

Broker Appointment - Electronic Quiz

- A link will be shared following the training session and will be sent to the communication email address on record
- Immediate score will be shown and sent to Community
- Please complete ALL NAME and NPN fields
- Please maintain a copy of the quiz for your records including your NAME and NPN pages
- Three attempts are allowed
- Must pass with 80% or above

BROKER AGREEMENT REMINDERS

- Agent/Agency must keep records for a period of 10 years as required by CMS
- Agent/Agency must comply with all applicable state and federal laws regarding solicitation of business including all state and federal confidentiality conflict of interest laws, rules and regulations
- Must comply with all State and Federal regulatory requirements including all disclaimers on enrollment materials and websites:
- Sample Language:
- "Attention: This website is operated by [Name of Company] and is not the Health Insurance Marketplace website. In offering this website, [Name of Company] is required to comply with all applicable federal law, including the standards established under 45 C.F.R. 155.220(c) and (d) and standards established under 45 C.F.R. 155.260 to protect the privacy and security of personally identifiable information. This website may not display all data on Qualified Health Plans being offered in your state through the Health Insurance Marketplace website. To see all available data on Qualified Health Plan options I in your state, go to Health Insurance Marketplace website at HealthCare.gov."
- Link: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Guidance-Web-brokers-Displaying-Disclaimers.pdf

Broker Agreement and Credentialing for 2024

- **Post Training -** all agents will complete the 2024 Benefit quiz and return the completed 2024 Broker Training Attestation form along with any other required documents

- Submit all required documents back to Agent Credentialing Department at **Agent.Credentialing@CommunityHealthChoice.org**

- For Agency sub-agents, commissions are payable to you by the Agency directly. Form 1099 is provided to you annually by your upline Agency

Agent of Record

- On-Exchange business bulk transfer process not currently in place per CMS

- Consent required by each consumer (AOR form) before you can proceed to:
  - conduct an online person search
  - assist with completing a Marketplace application
  - assist with plan selection and enrollment
  - assist with account/enrollment maintenance via Direct Enrollment Pathway

- Off-Exchange member AOR changes can be completed with proper form

For more information on the consumer consent requirement, see this resource: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB-Summit-Mastering-Agent-Broker-Compliance.pdf

BILLING, PAYMENT AND ENROLLMENT

Billing, Payment and Enrollment

- A cloud-based service is utilized to handle Community's enrollments and invoicing needs
- Community only receives the effectuated files (members who have paid their first premium) who are then loaded into the eligibility and claims payment systems
- Members will not receive materials including Member Welcome Packets or ID cards until the member has effectuated coverage and selected a Primary Care Physician
- Members must select a Primary Care Physician (PCP) or one will be assigned

Billing, Payment and Enrollment

- Once a member enrolls in a Community plan, they will be able to make their initial payment and any ongoing payments:
  - Online via our website
  - Pay-by-phone by calling Community directly
    - option to speak to a representative
    - option to pay by IVR payment prompts without speaking to an individual
  - Mailed money order or check payments to address on billing statement, which **must include** the payment coupon which has the subscriber ID for the payment to be applied to the account

- **Forms of Payment Accepted:**
  - Checking/Savings Account draft
  - Check
  - Credit card (Visa/Mastercard/Discover)
  - Debit card
  - Money Order

- **After** members have made their initial binder payment, they can set up recurring payments online. Payments will be deducted the 15th or the 25th of each month from the established account. This can also be completed after making the initial payment at the time of enrollment.

- Automatic payments do not end at the end of the year. If necessary, it is important that the member update their payment method at time of renewal, and it is recommended that they do not cancel automatic payments.

- Members who are set up on recurring payments for 2024 that renew for 2024 will only be required to re-establish recurring payments if they selected the "other amount" payment option when creating their account

Member recurring payment options

- Members can set up or manage recurring payments online
- Automatic Payments can be made by checking/savings account or credit card
- Payment options include the 15th or 25th of the month (please note payments are due prior to the coverage month)

Recurring Payment Options

Option 1: Total Amount Due

By selecting total amount due the member is agreeing to pay the full amount owed, including any outstanding payments. This option will capture and retro activity or any financial changes

Option 2: Monthly Premium

By selecting monthly premium, the member is agreeing to pay only the monthly premium amount (not any outstanding payments owed). Please note, if this amount is less than what is due, they will go into Grace Period.

Option 3: Other Amount

By selecting other amount, the member is agreeing to pay only the amount entered (or an amount they have decided at the time auto payments were set up). Please note, if this amount is less than what is due, they will go into Grace Period.

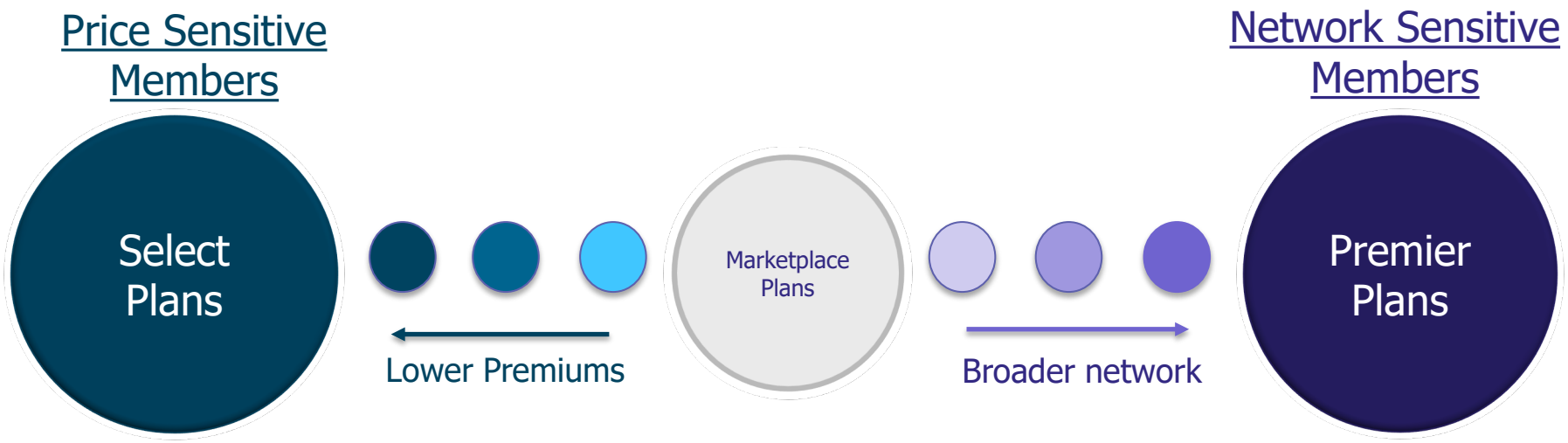
Billing Cycle and Grace Period

- Member's premiums are due by the first day of the coverage month
  - e.g., February's premium is due no later than February 1st
- Payments not received by the first day of the coverage month are considered late
- Terminations are processed on the 1st of each month
- Members who have APTC receive a 3 month grace period **only after** the binder payment has been made in full to effectuate coverage
- Members who do not have APTC receive a one month grace period **only after** the binder payment has been made in full to effectuate coverage
- Members who enter grace will only come out of grace period if all current and past due premiums are paid before the end of the grace period cycle

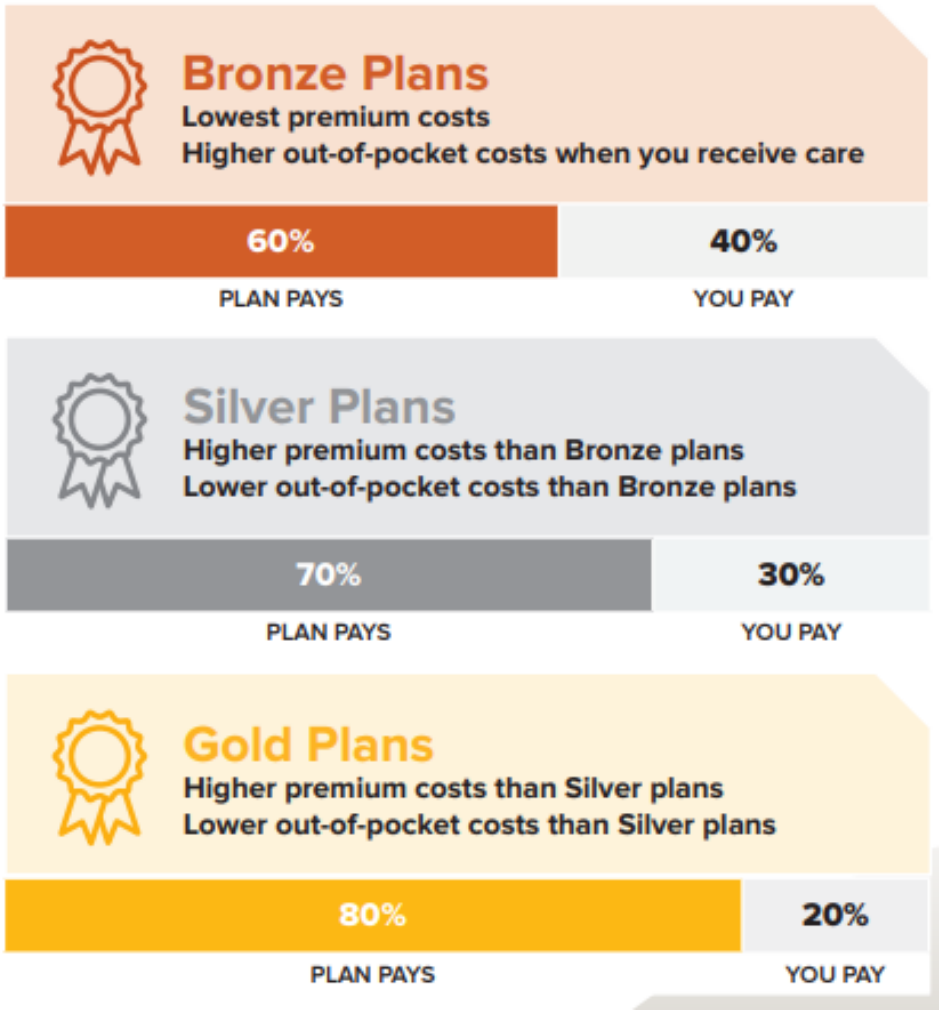
PLANS, BENEFITS & RATES

Why Community?

1. Affordable
2. Broad Network with High Quality Providers
3. Four-star enrollee experience with excellent customer service
4. Ease of approval of care for variety of benefits
5. *Wide array of products that target shoppers all along the price sensitivity spectrum with introduction of Select plans*



Metal Tiers



	Enrollment Percentage	Consumer Profile
Bronze Plans	15%	Generally, healthy with minimal expectations of consuming care
Silver Plans	60%	Have some minor conditions and expect moderate consumption of services
Gold Plans	25%	High utilizers of care with more severe medical conditions

Standardized Plans

Q: What are Standardized plans?

A: Standardized plans are plans mandated by CMS where they dictate the benefit levels. All issuers are required to sell 1 Bronzes, 1 Silver, and 1 Gold in their market.

- Community Health Choice
  - Premier Bronze 18
  - Premier Silver 20
  - Premier Gold 21

Expectations of these plans

- Priced higher than average in their metal tier – depending on the plan, therapy services and Preferred Brand, Non-Preferred Brand, and Specialty are exempt from the deductible
- Enrollment should be minimal.
- Selling in all counties
- Not being preferentially displayed, just differentially displayed on Healthcare.gov

Advanced Premium Tax Credits (APTC)

- Tax credit subsidies available through the exchange are called Advanced Premium Tax Credits (APTC)
- APTC's assist members with their monthly premium
- Who is eligible for APTC?
  - Individual earns between 100%-400% Federal Poverty Level (FPL)
  - Individual is not eligible for coverage through their employer, Medicaid, or Medicare*
    - Or employer sponsored coverage is less than 9.12% of their income
    - Or employer sponsored coverage doesn't meet minimum essential coverage requirements
- The only way to get APTC is to enroll "On Exchange"

Cost Sharing Reduction Plans

- CSR's will still exist in 2024
- Enrollees <250% Federal Poverty Level (FPL) are eligible for Cost Sharing Reduction (CSR) plans
- **Only Silver level plans have CSR benefits**
- Cost Sharing Reductions mean reduced copays, coinsurances, and lower out-of-pocket maximums
- There are 3 Silver CSR plans:
    - Silver 73 = 201-250% FPL
    - Silver 87 = 151-200% FPL
    - Silver 94 = 100-150% FPL
    - If a potential enrollee earns <100% FPL, they are not eligible for CSR plans unless they meet specific criteria

Limited and Zero Cost Sharing Plans

If a consumer is a member of the federally recognized tribe or an Alaska Native Claims Settlement Act Corporation shareholder, they may qualify for additional cost-sharing reductions.

To learn more: https://www.healthcare.gov/american-indians-alaska-natives/

Zero Cost Sharing Plans

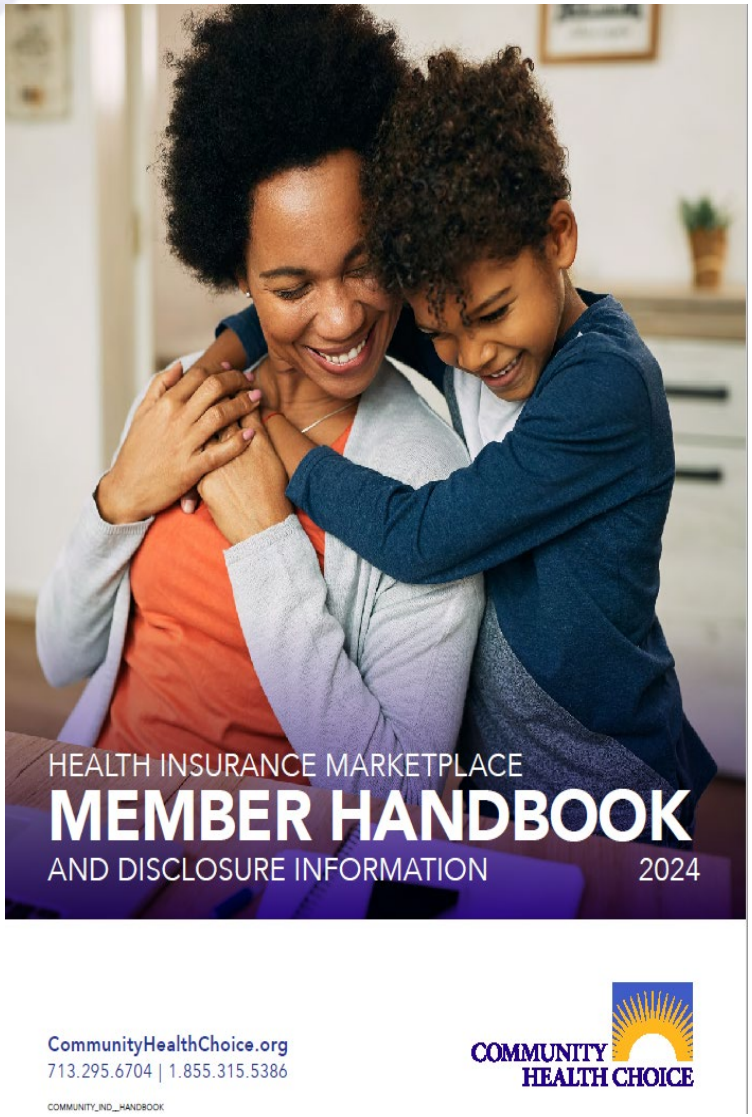
- Native Americans,100-300% FPL and qualify for APTC
- Pay $0 copays or 0% coinsurance
  - Gold Zero Cost Sharing
  - Silver Zero Cost Sharing
  - Bronze Zero Cost Sharing

Limited Cost Sharing Plans

- Pay $0 copays or 0% coinsurance at Indian Health Service Providers* only
  - Gold Limited Cost Sharing
  - Silver Limited Cost Sharing
  - Bronze Limited Cost Sharing

*There are currently no Indian Health Service Providers in our service area

Open Enrollment – Things to Know



KEY DATES

- **November 1, 2023:**
  Open Enrollment starts
- **December 15, 2023:**
  Enroll by this date for coverage starting January 1, 2024:
- **January 15, 2024:**
  Open Enrollment ends

Member Handbook

USING YOUR **BENEFITS**

Benefit Information

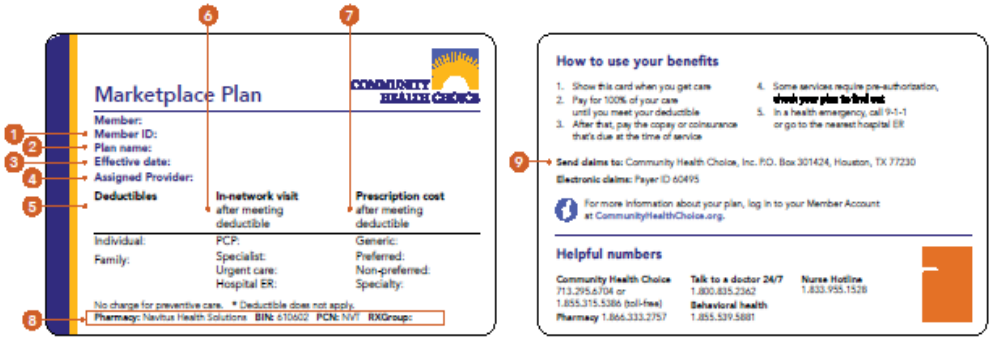
You may obtain all Member benefit information online at www.CommunityHealthChoice.org through your My Member Account page. You may also contact Community Member Services at 713.295.6704, toll-free at 1.855.315.5386 or email MemberServices@CommunityHealthChoice.org.

Creating a Member Account

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**



1 **MEMBER ID**
Your unique identifier. Use this ID number for all claims and inquiries. This is also the number used to create your My Member Account.

2 **PLAN NAME**
This is the plan you selected.

3 **EFFECTIVE DATE**
Date coverage begins.

4 **ASSIGNED PROVIDER**
Name of your Primary Care Provider.

5 **DEDUCTIBLE**
The amount you must pay for health care expenses before insurance covers the costs.

6 **COST SHARING**
The share of costs covered by your insurance that you pay out of your own pocket.

7 **PRESCRIPTION COST**
The amount you must pay for medication.

8 Your pharmacist will use this information to process your prescription.

9 Your Provider will use this information to process your claim.

Member Handbook

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 (Eligibility/Authorizations/Benefits/Claims)	713.295.6704

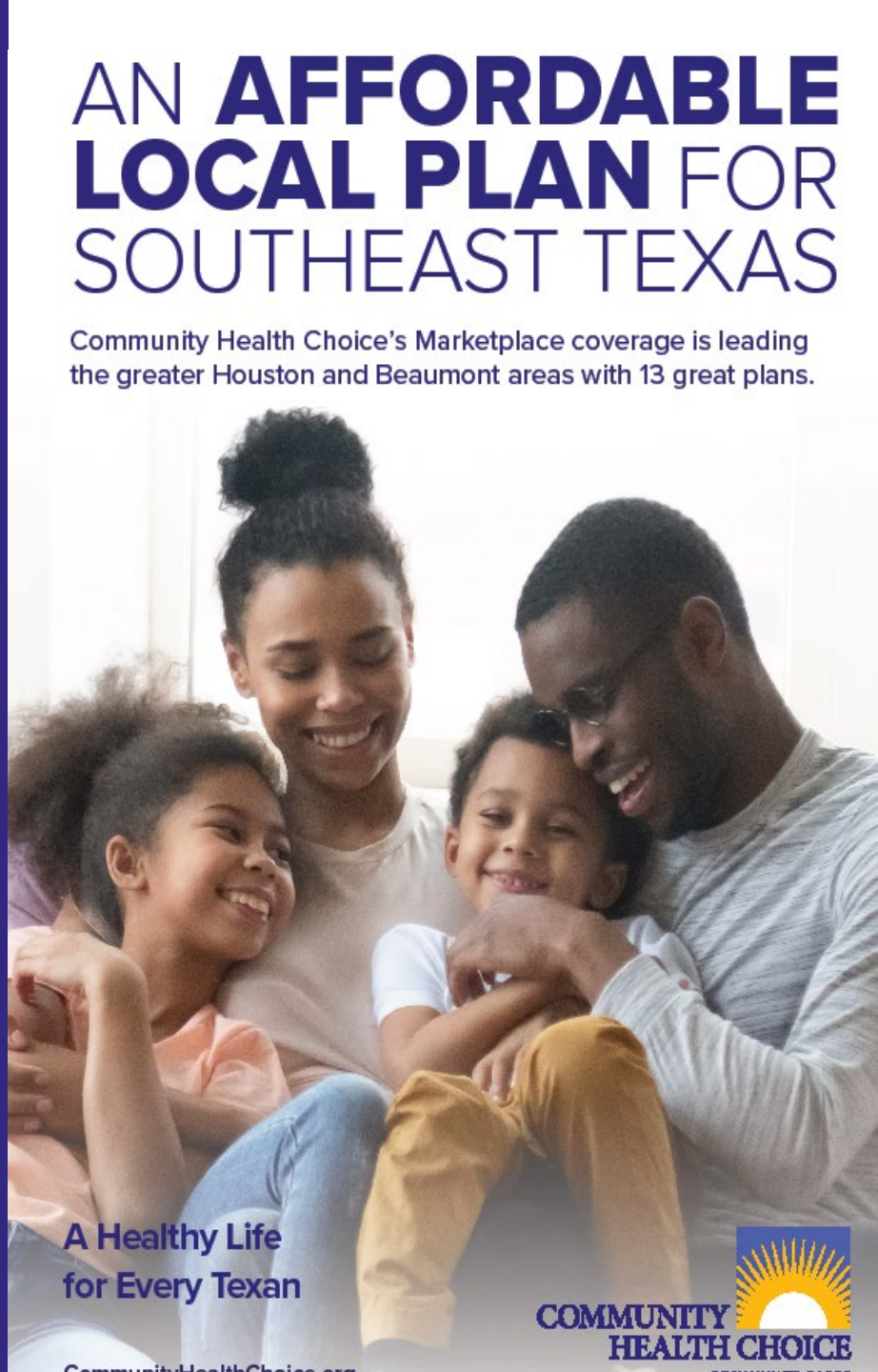
Information is available in English and Spanish or call COMMUNITY to get an interpreter.

7-1-1	TDD for Hearing-Impaired	
1.800.835.2362	Teladoc * Teladoc telehealth services are available to Members enrolled in all Marketplace plans except Community Premier Virtual 11.	
1.833.955.1528	Medical Advice Line	
1.866.646.6963	Doctor On Demand * Doctor On Demand virtual services are available to Members enrolled in Community Premier Virtual 11 plan	
1.866.333.2757	Pharmacy (Navitus Health Solutions)	Navitus.com
1.800.552.6694	Mail-Order Pharmacy Portal Precription Services – a subsidiary of The Kroger Co.	Ppsrx.com (Kroger Mail Order)
1.844.293.1752	Vision (Evolve Vision)	visionbenefits.envolvehealth.com
1.855.539.5881	Behavioral Health/Substance Abuse Services	CommunityHealthChoice.org
1.877.888.0002	Waste, Abuse or Fraud Hotline	

Write or visit us at:
Community Health Choice, Inc.
2636 South Loop West, Suite 125
Houston, TX 77054
www.CommunityHealthChoice.org

In case of an emergency call 9-1-1 or go to the nearest emergency room.

2024 SALES GUIDE



What's New for PY24 Marketplace

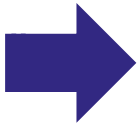
PY 2023 Plans – 14 Total

Bronze	Bronze 03
	Bronze 11
	Bronze 16
	Bronze 17
	Bronze 18
Silver	Silver 04
	Silver 12
	Silver 13
	Silver 19
	Silver 20
Gold	Gold 01
	Gold 05
	Gold 21
	Gold 22

Changes for PY24

Discontinuation of One Plan

- Bronze 17



PY 2024 Plans – 13 Total

Bronze	Bronze 03
	Bronze 11
	Bronze 16
	Bronze 18
Silver	Silver 04
	Silver 12
	Silver 13
	Silver 19
	Silver 20
Gold	Gold 01
	Gold 05
	Gold 21
	Gold 22

Crosswalk PY23 to PY24

	PY2023	PY2024
Bronze	27248TX0010003	27248TX0010003
	27248TX0010011	27248TX0010011
	27248TX0010018	27248TX0010018
	27248TX0010016	27248TX0010016
	~~27248TX0010017~~	
Silver	27248TX0010004	27248TX0010004
	27248TX0010012	27248TX0010012
	27248TX0010013	27248TX0010013
	27248TX0010019	27248TX0010019
	27248TX0010020	27248TX0010020
Gold	27248TX0010001	27248TX0010001
	27248TX0010005	27248TX0010005
	27248TX0010021	27248TX0010021
	27248TX0010022	27248TX0010022

Community Plan Names

All Community plans have the same name for 2024

The naming convention follows the following method:

Community + (Keyword) + (Metal Tier) + (Plan ID number) + (Description of key plan benefits)

Example:

Where space is limited *(ex: ID Cards)* the **descriptive** part of plan name will **not be used**.

- Premier = Broad Network Plan
- Select = Narrow Network Plan

Limited Network Plans – Called "Select" Plans

Purpose: To offer price-competitive products that target price-sensitive members (thus unlocking a market segment that typically avoided our broad network products)

Details:

- **Being sold in Harris County only to residents of Harris County**
- **Members are able to see Limited Network providers outside of Harris County if the providers have practice locations outside of Harris County**

Hospital System	Affiliated Physician Groups
Memorial Hermann (Anchor) – includes facilities in Harris SDA (i.e., means not just limited to Harris County)	• MHHG • MHMD • UT physicians
Harris Health	• UT physicians • Baylor College of Medicine
St. Joseph	• Steward Health Network ACO
	• Legacy Clinics (FQHC)

PY24 Plan Design Summary

Plans			Services Not Subject to a Deductible					
	Deductible	MOOP	PCP	Specialist Care	Generics	24/7 Telehealth	Preventive Care	Urgent Care
Premier Virtual Bronze 11	$9,450	$9,450	✓ DOD ONLY				✓	
Premier Bronze 03	$7,700	$9,450	✓		✓	✓	✓	✓
Premier Bronze 18**	$7,500	$9,400	✓	✓	✓	✓	✓	✓
Select Bronze 16*	$8,100	$9,450	✓		✓	✓	✓	✓
Select Silver 19*	$4,500	$9,100	✓	✓	✓	✓	✓	✓
Premier Silver 04	$3,300	$9,450	✓	✓	✓	✓	✓	✓
Premier Silver 12	$3,000	$9,450	✓		✓	✓	✓	✓
Premier Silver 13	$9,100	$9,100	✓	✓	✓	✓	✓	✓
Premier Silver 20**	$5,900	$9,100	✓	✓	✓	✓	✓	✓
Premier Gold 21**	$1,500	$8,700	✓	✓	✓	✓	✓	✓
Select Gold 22*	$1,800	$9,450	✓	✓	✓	✓	✓	✓
Premier Gold 01	$0	$9,450	✓	✓	✓	✓	✓	✓
Premier Gold 05	$1,600	$9,450	✓	✓	✓	✓	✓	✓

*Select Plan
**Standardized Plan

2024 BRONZE PLANS

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Bronze

PLANS/VISITS	PREMIER BRONZE 003 PLAN ID 27248TX0010003	PREMIER VIRTUAL BRONZE 11 PLAN ID 27248TX0010011	SELECT BRONZE 016 PLAN ID 27248TX0010016	PREMIER BRONZE 18 PLAN ID 27248TX0010018
Medical Deductible (individual/family)	$7,700 / $15,400	$9,450 / $18,900	$8,100 / $16,200	$7,500 / $15,000
Out-of-Pocket Max (individual/family)	$9,450/$18,900	$9,450 / $18,900	$9,450 / $18,900	$9,400 / $18,800
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35	*$50
Specialist Office Visit	$70	No charge after deductible	$90	*$100
Outpatient Facility	40%		50%	50%
Outpatient Surgery	40%		50%	50%
Urgent Care Services	*$70		*$90	*$75
Ambulance Services	$70		$90	$100
Emergency Room Services	40%		50%	50%
Inpatient Hospital Care	40%		50%	50%
Inpatient Skilled Nursing Facility	40%		50%	50%
Outpatient Mental/Behavioral Substance Abuse	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35	*$50
Inpatient Mental/Behavioral Substance Abuse	40%	No charge after deductible	50%	50%
Outpatient Rehabilitation	$70		$90	$100
Medical Imaging (CT/PET Scans, MRIs)	40%		50%	50%
Routine Lab/X-Ray/Diagnostic Imaging	$40		$35	50%
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$16	No charge after deductible	*$30	*$25
Preferred Brand	$70		$60	$50
Non-Preferred Brand	$120		$130	$100
Specialty High-Cost Drugs	45%		50%	$500

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

2024 SILVER PLANS

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY PREMIER SILVER 004 PLAN ID 27248TX0010004			
	SILVER 004 251% FPL AND ABOVE	**SILVER 004 (73)** 201%-250% FPL	**SILVER 004 (87)** 151%-200% FPL	**SILVER 004 (94)** 100%-150% FPL
Medical Deductible (individual/family)	$3,300 / $6,600	$3,200 / $6,400	N/A	N/A
Out-of-Pocket Max (individual/family)	$9,450 / $18,900	$7,500 / $15,000	$3,000 / $6,000	$2,000 / $4,000
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$30	*$30	$25	$10
Specialist Office Visit	*$60	*$60	$50	$20
Outpatient Facility	40%	40%	40%	10%
Outpatient Surgery	40%	40%	40%	10%
Urgent Care Services	*$60	*$60	$50	$20
Ambulance Services	$60	$60	$50	$20
Emergency Room Services	40%	40%	40%	10%
Inpatient Hospital Care	40%	40%	40%	10%
Inpatient Skilled Nursing Facility	40%	40%	40%	10%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	$25	$10
Inpatient Mental/Behavioral Substance Abuse	40%	40%	40%	10%
Outpatient Rehabilitation	$60	$60	$50	$10
Medical Imaging (CT/PET Scans, MRIs)	40%	40%	40%	10%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$25	$10
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	N/A	N/A
Generic	*$10	*$10	$10	$5
Preferred Brand	$70	$60	$50	$20
Non-Preferred Brand	$110	$100	$85	$40
Specialty High-Cost Drugs	50%	40%	30%	20%

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

CommunityHealthChoice.org

2024 SILVER PLANS…

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY PREMIER SILVER 12 PLAN ID 27248TX0010012				COMMUNITY PREMIER SILVER 13 PLAN ID 27248TX0010013			
	SILVER 12 251% FPL AND ABOVE	**SILVER 12 (73)** 201%-250% FPL	**SILVER 12 (87)** 151%-200% FPL	**SILVER 12 (94)** 100%-150% FPL	**SILVER 13** 251% FPL AND ABOVE	**SILVER 13 (73)** 201%-250% FPL	**SILVER 13 (87)** 151%-200% FPL	**SILVER 13 (94)** 100%-150% FPL
Medical Deductible (individual/family)	$3,000 / $6,000	$2,500 / $5,000	$500 / $1,000	N/A	$9,100 / $18,200	$7,500 / $15,000	$2,200 / $4,400	$700 / $1,400
Out-of-Pocket Max (individual/family)	$9,450 / $18,900	$7,100 / $14,200	$2,500 / $5,000	$1,800 / $3,600	$9,100 / $18,200	$7,500 / $15,000	$2,200 / $4,400	$700 / $1,400
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$25	$10	*$10	*$10	*$10	*$5
Specialist Office Visit	$60	$60	$50	$20	*$20	*$15	*$15	*$10
Outpatient Facility	50%	50%	30%	10%	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery	50%	50%	30%	10%				
Urgent Care Services	*$60	*$60	*$50	$20	*$20	*$15	*$15	*$10
Ambulance Services	$60	$60	$50	$20	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Room Services	50%	50%	40%	10%				
Inpatient Hospital Care	50%	50%	40%	10%				
Inpatient Skilled Nursing Facility	50%	50%	40%	10%				
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$25	$10	*$10	*$10	*$10	*$5
Inpatient Mental/Behavioral Substance Abuse	50%	50%	40%	10%	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Rehabilitation	$60	$60	$50	$20				
Medical Imaging (CT/PET Scans, MRIs)	50%	50%	40%	10%				
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$25	$10				
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE							
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$10	*$10	*$5	$5	*$10	*$5	*$5	*$5
Preferred Brand	$80	$80	$70	$20	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Non-Preferred Brand	$120	$120	$100	$40				
Specialty High-Cost Drugs	50%	50%	40%	20%				

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

2024 SILVER PLANS…

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY SELECT SILVER 19 PLAN ID 27248TX0010019				COMMUNITY PREMIER SILVER 20 PLAN ID 27248TX0010020			
	SILVER 19 251% FPL AND ABOVE	**SILVER 19 (73)** 201%-250% FPL	**SILVER 19 (87)** 151%-200% FPL	**SILVER 19 (94)** 100%-150% FPL	**SILVER 20** 251% FPL AND ABOVE	**SILVER 20 (73)** 201%-250% FPL	**SILVER 20 (87)** 151%-200% FPL	**SILVER 20 (94)** 100%-150% FPL
Medical Deductible (individual/family)	$4,500 / $9,000	$3,500 / $7,000	$500 / $1,000	N/A	$5,900 / $11,800	$5,700 / $11,400	$700 / $1,400	N/A
Out-of-Pocket Max (individual/family)	$9,100 / $18,200	$7,250 / $14,500	$3,000 / $6,000	$1,600 / $3,200	$9,100 / $18,200	$7,200 / $14,400	$3,000 / $6,000	$1,800 / $3,600
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$20	$5	*$40	*$30	*$20	$0
Specialist Office Visit	*$80	*$80	*$40	$25	*$80	*$60	*$40	$10
Outpatient Facility	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Surgery	40%	30%	30%	10%	40%	40%	30%	25%
Urgent Care Services	*$80	*$80	*$40	$25	*$60	*$45	*$30	$5
Ambulance Services	$80	$80	$40	$25	$80	$60	$40	$10
Emergency Room Services	40%	30%	30%	10%	40%	40%	30%	25%
Inpatient Hospital Care	40%	30%	30%	10%	40%	40%	30%	25%
Inpatient Skilled Nursing Facility	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$20	$5	*$40	*$30	*$20	$0
Inpatient Mental/Behavioral Substance Abuse	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Rehabilitation	$80	$80	$40	$25	*$40	*$30	*$20	$10
Medical Imaging (CT/PET Scans, MRIs)	40%	30%	30%	10%	40%	40%	30%	25%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$20	$5	40%	40%	30%	25%
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE							
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A
Generic	*$10	*$10	*$10	$5	*$20	*$20	*$10	$0
Preferred Brand	$40	$40	$25	$15	*$40	*$40	*$20	$15
Non-Preferred Brand	$100	$80	$60	$40	$80	$80	$60	$50
Specialty High-Cost Drugs	50%	50%	50%	30%	$350	$350	$250	$150

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

CommunityHealthChoice.org

2024 GOLD PLANS

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Gold

PLANS/VISITS	PREMIER GOLD 001 OFF-EXCHANGE PLAN ID 27248TX0010001	PREMIER GOLD 005 PLAN ID 27248TX0010005	PREMIER GOLD 021 PLAN ID 27248TX0010021	SELECT GOLD 022 PLAN ID 27248TX0010022
Medical Deductible (individual/family)	N/A	$1,600/ $3,200	$1,500/ $3,000	$1,800/ $3,600
Out-of-Pocket Max (individual/family)	$9,450 / $18,900	$9,450 / $18,900	$8,700 / $17,400	$9,450 / $18,900
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	$30	*$20	*$30	*$15
Specialist Office Visit	$65	*$40	*$60	*$30
Outpatient Facility	$300	25%	25%	30%
Outpatient Surgery	$300	25%	25%	30%
Urgent Care Services	$65	*$40	*$45	*$30
Ambulance Services	$65	$40	$60	$30
Emergency Room Services	$800	25%	25%	30%
Inpatient Hospital Care	**$800	25%	25%	30%
Inpatient Skilled Nursing Facility	**$800	25%	25%	30%
Outpatient Mental/Behavioral Substance Abuse	$30	*$20	*$30	*$15
Inpatient Mental/Behavioral Substance Abuse	**$800	25%	25%	30%
Outpatient Rehabilitation	$65	$40	*$30	$30
Medical Imaging (CT/PET Scans, MRIs)	$500	25%	25%	30%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$20	25%	$15
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/family) (90-day mail order supply available at 2.5 times copay)	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	$25	*$10	*$15	*$10
Preferred Brand	$40	$50	*$30	*$50
Non-Preferred Brand	$80	$75	*$60	$100
Specialty High-Cost Drugs	30%	35%	*$250	40%

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX)
** Copay applies for first 5 days of admission for all inpatient services
For Deductible Plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated

CommunityHealthChoice.org

Scenario 1:

- 50-year-old female
- Annual income: $24,000 (Eligible for 87% CSR)
- Lives in Harris County
- Has Memorial Hermann PCP
- Has multiple chronic conditions
- Currently deciding between two Silver plans

Option 1: Enroll in Silver 12

Monthly Premium (based on 50-YO non-smoker)	**$830.53** (Not factoring APTC)
Actuarial Value	87.61%
Deductible	$500
MOOP	$2,500
PCP	$25 (exempt from deductible)
Specialist	$50 after deductible
Inpatient	40% coinsurance after deductible

Option 2: Enroll in Select Silver 19 with lower premiums and comparable OOP costs

Monthly Premium (based on 50-YO non-smoker)	**$657.08** (Not factoring APTC)
Actuarial Value	87.23%
Deductible	$500
MOOP	$3,000
PCP	$20 (exempt from deductible)
Specialist	$40 (exempt from deductible)
Inpatient	30% coinsurance after deductible

Scenario 2:

- 60-year-old female
- Annual income: $30,000 (Eligible for 73% CSR)
- Lives in Harris County
- Has Harris Health PCP
- Has multiple chronic conditions
- Currently enrolled in a Silver 04 plan

Option 1: Re-enroll and stay in Silver 04

Monthly Premium (based on 60-YO non-smoker)	**$1273.71** (Not factoring APTC)
Actuarial Value	73.74%
Deductible	$3,200
MOOP	$7,500
PCP	$30 (exempt from deductible)
Specialist	$60 (exempt from deductible)
Inpatient	40% coinsurance after deductible

Option 2: Re-enroll but migrate to Gold 22 with lower premiums and comparable OOP expenses

Monthly Premium (based on 60-YO non-smoker)	**$862.84** (Not factoring APTC)
Actuarial Value	78.13%
Deductible	$1,800
MOOP	$9,450
PCP	$15 (exempt from deductible)
Specialist	$30 (exempt from deductible)
Inpatient	30% coinsurance after deductible

Scenario 3:

- Young family of 3 with toddler
- Annual income: $80,000
- (Not Eligible for CSRs)
- Lives in Montgomery County
- Busy lifestyle
- Parents are generally healthy but need routine care for child

Bronze 11 Virtual Plan Overview	
Actuarial Value	63.27%
Deductible (Family)	$9,450 (18,900)
MOOP (Family)	$9,450 (18,900)
PCP	Tier 1: $0 for DOD virtual provider Tier 2: No Charge after deductible for other providers
Specialist	No Charge after deductible for other providers
Inpatient	No Charge after deductible for other providers
ER Visits	No Charge after deductible for other providers

Benefits

1. Available 24/7 at $0
2. Can make on-demand or appointment visits with providers
3. Able to see behavioral health providers such as therapists, counselors,
4. Can see virtual doctor outside Texas
5. Providers can make prescriptions and order labs

Telehealth Services

Available to ALL Marketplace Members EXCEPT those enrolled in the Community Premier Virtual 11 plan

- Access 24/7/365
- Video and Telephone Consultations
- Board-Certified Doctors
- Use for treatment of routine conditions such as:
  - Cold and Flu
  - Respiratory Infections
  - Bronchitis
  - Allergies
  - Urinary Tract Infections
  - Skin Problems
  - And More
- Services NOT Subject to Deductible

Doctor on Demand (DOD)

- **Members enrolled in Community Premier Virtual 11 plan**
  - Members **MUST** access virtual medicine services through Doctors on Demand
  - **Video and Telephone Consultations**
  - Board-Certified Providers
  - Services received **through** DOD are covered 100% with no member Out of Pocket
  - Services received **outside** DOD are subject to the plan deductible
  - **Includes both Primary Care and Mental and Behavioral Health Providers**
  - **Also includes clinical care teams to support such as RNs, LPNs, Diabetes Educators, Lactation Consultants, Health Coaches, Referral Coordinators, and Social Workers**

2024 Deductible Plans

- **All** of Community deductible plans have a **combined (Prescription + Medical)** deductible
- PCP visits are not subject to deductible for **All plans.**
- Urgent Care visits are not subject to deductible for **all plans except Premier Virtual Bronze 11.**
- Generic Drugs are not subject to deductible for **all plans except Premier Virtual Bronze 11.**

2024 Copay Plan

- Gold Copay 001 is the only Off Exchange copay plan
- Copays apply to any covered service from day one
- Inpatient copay applies for the first 5 days of admission for all inpatient stays
- Specialty high-cost drugs have a coinsurance

Impact of SB 1296 Gold-Silver Swap

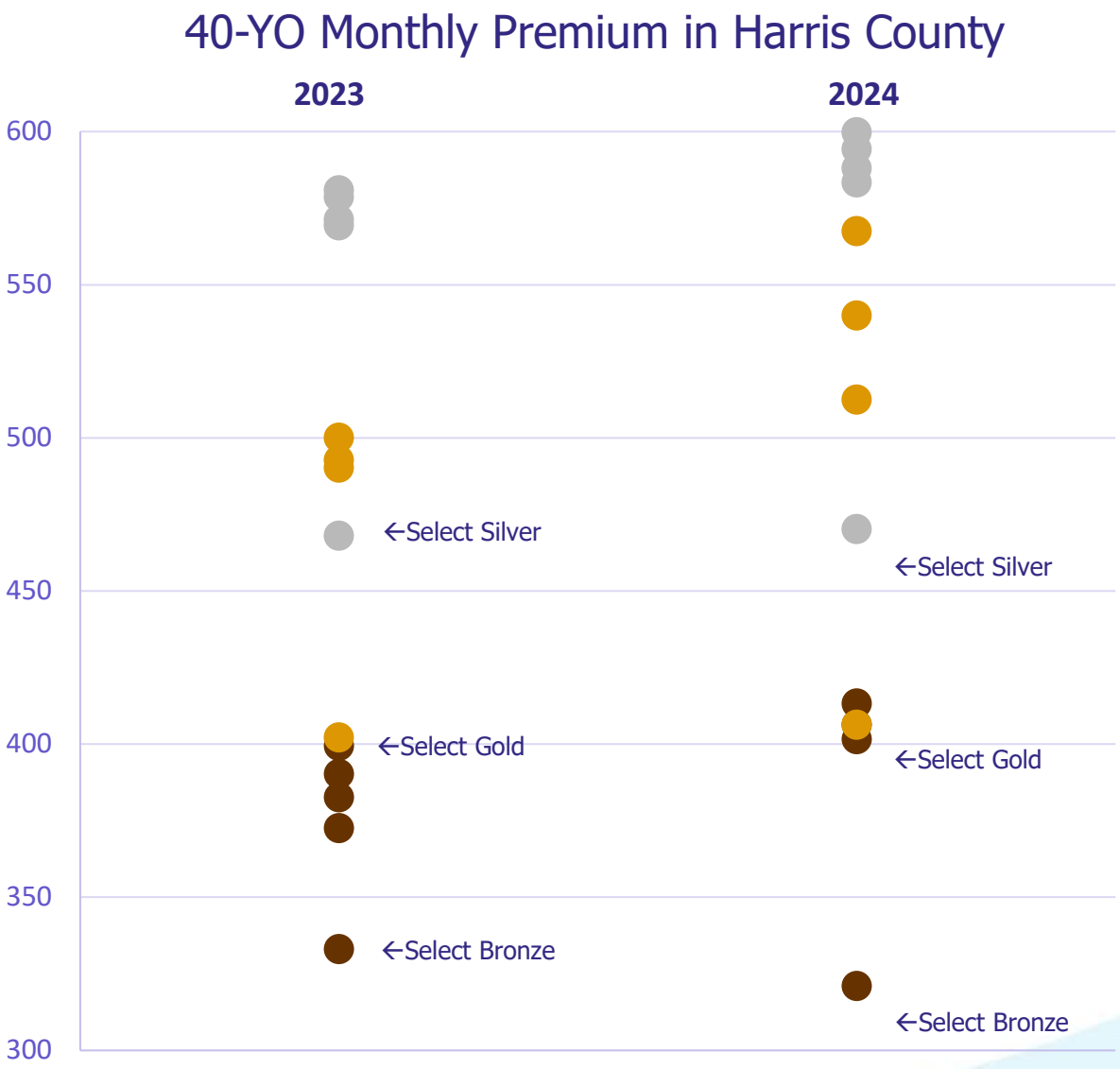
Pre SB 1296

- **Bronze:** Lowest premiums and higher out-of-pocket costs
- **Silver:** Medium premiums and medium out-of-pocket costs
- **Gold:** Highest premiums and lower out-of-pocket costs

Post SB 1296

- **Bronze:** Lowest premiums and higher out-of-pocket costs
- **Silver:** Highest premiums and lower out-of-pocket costs than a bronze plan but higher than a gold plan, depending on CSR eligibility
- **Gold plans:** Medium premiums and lower out-of-pocket costs

Metal Tier Changes – 2024 Rate Overview



Premium Changes for Current PY23 Enrollees

Metal Tier	PY2023 Enrolled Plan	Rate Increase	Crosswalk into PY24 Plan
Bronze	27248TX0010003	4.08%	27248TX0010003
	27248TX0010011	11.48%	27248TX0010011
	27248TX0010018	1.06%	27248TX0010018
	27248TX0010016	-3.63%	27248TX0010016
	~~27248TX0010017~~	8.57%	27248TX0010011
Silver	27248TX0010004	3.80%	27248TX0010004
	27248TX0010012	4.92%	27248TX0010012
	27248TX0010013	-1.06%	27248TX0010013
	27248TX0010020	3.47%	27248TX0010020
	27248TX0010019	0.46%	27248TX0010019
Gold	27248TX0010001	14.09%	27248TX0010001
	27248TX0010005	5.07%	27248TX0010005
	27248TX0010021	10.15%	27248TX0010021
	27248TX0010022	1.05%	27248TX0010022

Rates

Community will have separate Rate Grids for 2024 that will be separated by Metal plans. PDF versions can be provided vial email or hard copy.

COMMUNITY HEALTH CHOICE 2024 RATES

COMMUNITY HEALTH CHOICE

Bronze Deductible Plans

AGE BAND	COMMUNITY PREMIER BRONZE 003 PLAN ID 27248TX0010003		COMMUNITY PREMIER VIRTUAL BRONZE 011 PLAN ID 27248TX0010011		COMMUNITY SELECT BRONZE 016 *IN HARRIS COUNTY ONLY* PLAN ID 27248TX0010016		COMMUNITY PREMIER BRONZE 018 PLAN ID 27248TX0010018	
	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco	No Tobacco	Tobacco
0-14	241.87	241.87	247.36	247.36	192.13	192.13	240.41	240.41
15	263.37	263.37	269.35	269.35	209.21	209.21	261.77	261.77
16	271.59	271.59	277.75	277.75	215.74	215.74	269.95	269.95
17	279.81	279.81	286.16	286.16	222.27	222.27	278.12	278.12
18	288.66	288.66	295.21	295.21	229.30	229.30	286.92	286.92
19	297.52	297.52	304.27	304.27	236.34	236.34	295.71	295.71
20	306.69	306.69	313.64	313.64	243.62	243.62	304.83	304.83
21	316.17	379.40	323.34	388.01	251.16	301.39	314.26	377.11
22	316.17	379.40	323.34	388.01	251.16	301.39	314.26	377.11
23	316.17	379.40	323.34	388.01	251.16	301.39	314.26	377.11
24	316.17	379.40	323.34	388.01	251.16	301.39	314.26	377.11
25	317.44	380.93	324.64	389.57	252.16	302.59	315.51	378.61
26	323.76	388.51	331.10	397.32	257.18	308.62	321.80	386.16
27	331.35	397.62	338.86	406.63	263.21	315.85	329.34	395.21
28	343.68	412.42	351.48	421.78	273.01	327.61	341.60	409.92
29	353.80	424.56	361.82	434.18	281.04	337.25	351.65	421.98
30	358.85	430.62	367.00	440.40	285.06	342.07	356.68	428.02
31	366.44	439.73	374.76	449.71	291.09	349.31	364.22	437.06
32	374.03	448.84	382.52	459.02	297.12	356.54	371.76	446.11
33	378.77	454.52	387.37	464.84	300.88	361.06	376.48	451.78
34	383.83	460.60	392.54	471.05	304.90	365.88	381.51	457.81
35	386.36	463.63	395.13	474.16	306.91	368.29	384.02	460.82

SERVICE AREA AND NETWORK

Marketplace Service Area

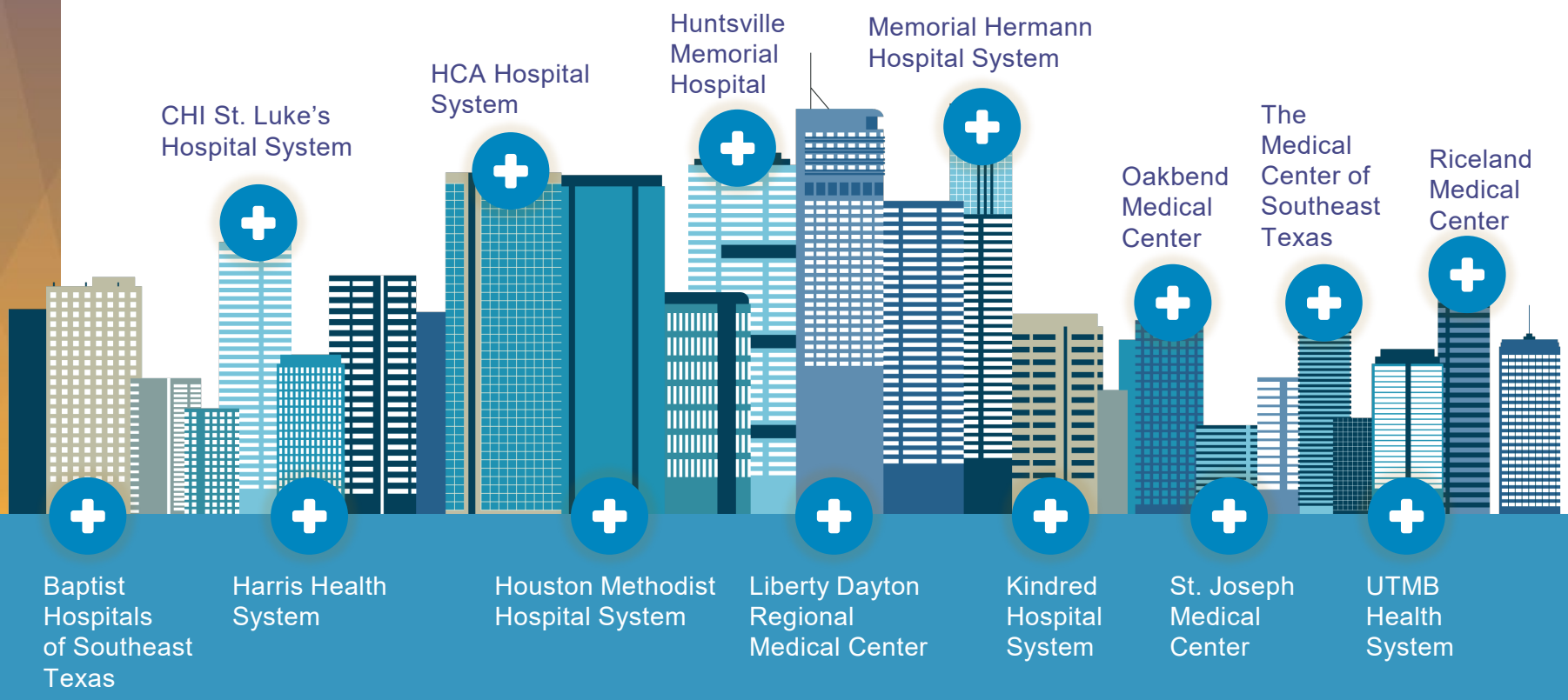
Where the Members Are

Community's service area consists of **20 counties in Texas.**

Members choosing our plans, **must live within** the Community Service Area.

- ★ **Austin**
- ★ **Brazoria**
- ★ **Chambers**
- ★ **Fort Bend**
- ★ **Galveston**
- ★ **Hardin**
- ★ **Harris**
- ★ **Jasper**
- ★ **Jefferson**
- ★ **Liberty**
- ★ **Matagorda**
- ★ **Montgomery**
- ★ **Newton**
- ★ **Orange**
- ★ **Polk**
- ★ **San Jacinto**
- ★ **Tyler**
- ★ **Walker**
- ★ **Waller**
- ★ **Wharton**

ACCESS TO ONE OF THE LARGEST HEALTH CARE NETWORKS



Committed To Ensuring Our Members Have Broad Access To Care

Varies based on plan selection

2024 Ancillary Network

- Doctor on Demand will provide Tier 1 Primary Care services to enrollees in the **Premier Virtual Bronze 11 plan**
- Navitus will continue to be our pharmacy vendor
- Rx mail-order vendor: Postal Prescription Services (a subsidiary of Kroger)
- Envolve Vision (only children 18 and under)
- Telehealth – Teladoc will be Telehealth provider **(Those members with access to Doctors on Demand will not have access to Teladoc)**
- Routine dental services are not covered by Community. Enrollees have the option to purchase stand-alone dental plans offered by other companies through the Marketplace or on their own

Provider Search

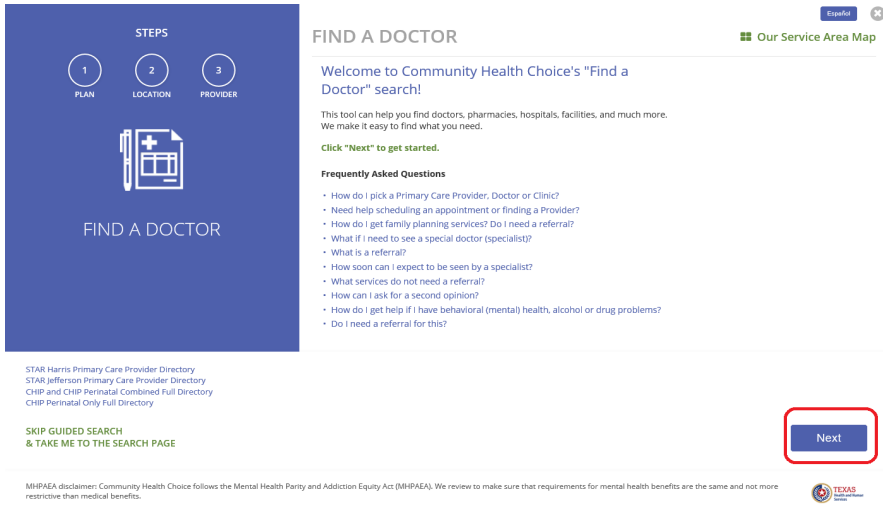
COMMUNITY HEALTH CHOICE MARKETPLACE PREMIER (PLAN YEAR 2023)

Community Health Choice Marketplace Premier (Plan Year 2023)

COMMUNITY HEALTH CHOICE MARKETPLACE SELECT LIMITED (PLAN YEAR 2023)

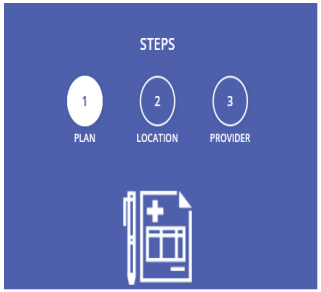
Community Health Choice Marketplace Select Limited (Plan Year 2023)

Provider Search

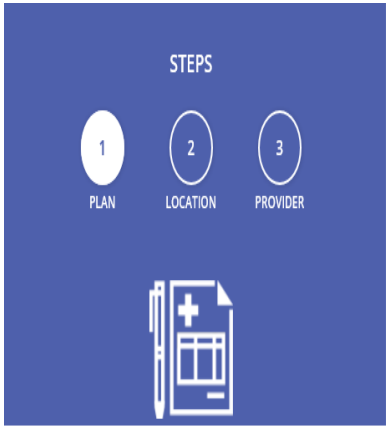


Step 1: At the FIND A DOCTOR Home Page, select "Next"

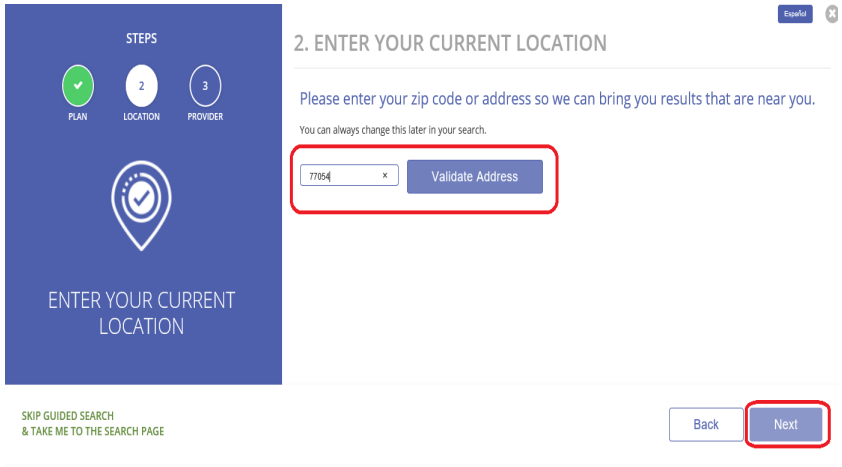
Step 2: Select Community Marketplace Plan



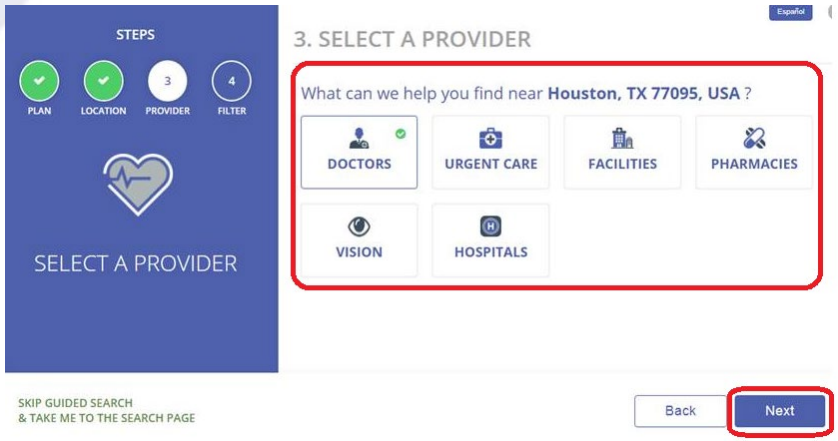
Provider Search



Step 3: Enter a Location
This can be an address or a zip code. You will select "Validate" then "Next"

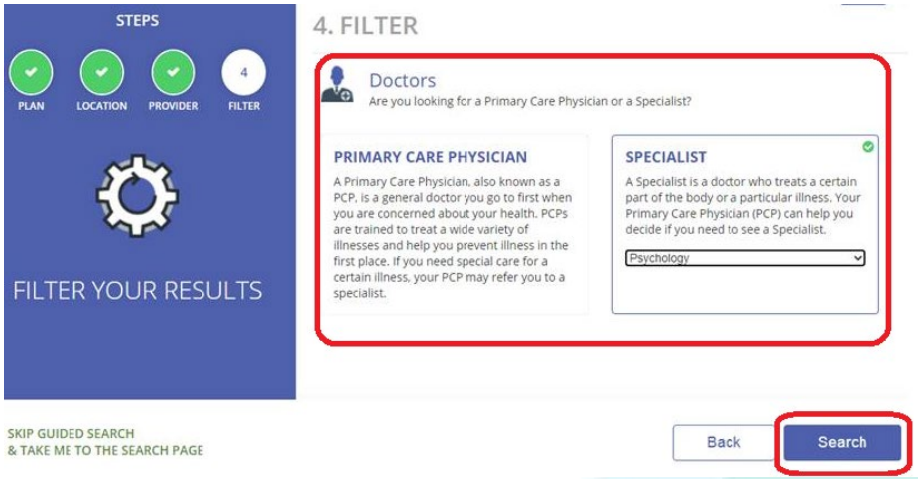


Provider Search



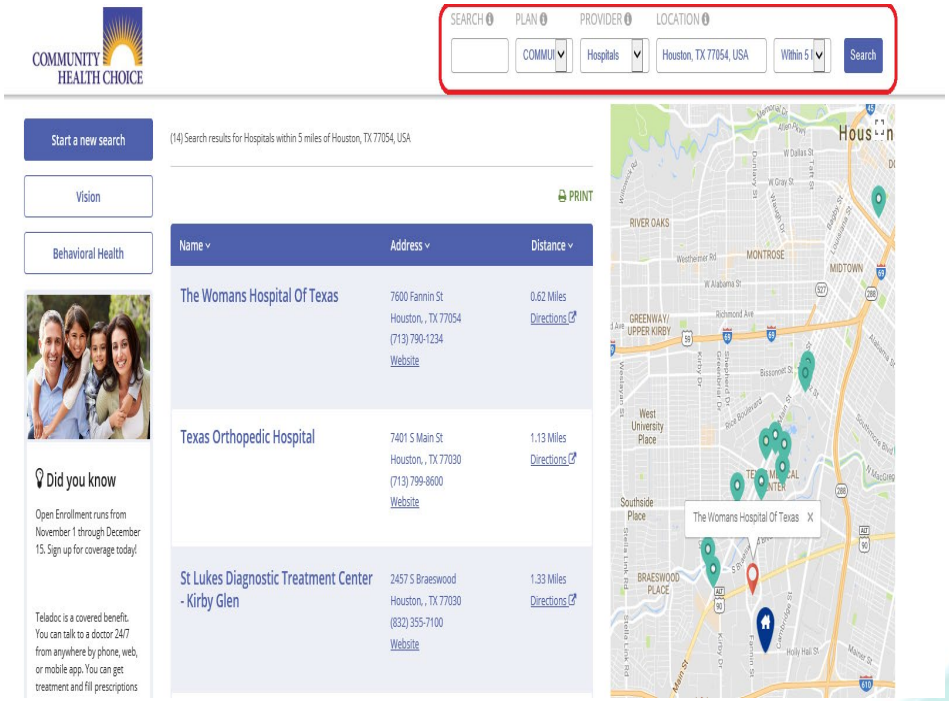
Step 4: Select the provider type you are searching for and then "Search".

Please note that Behavioral Health providers are listed as "Specialists"

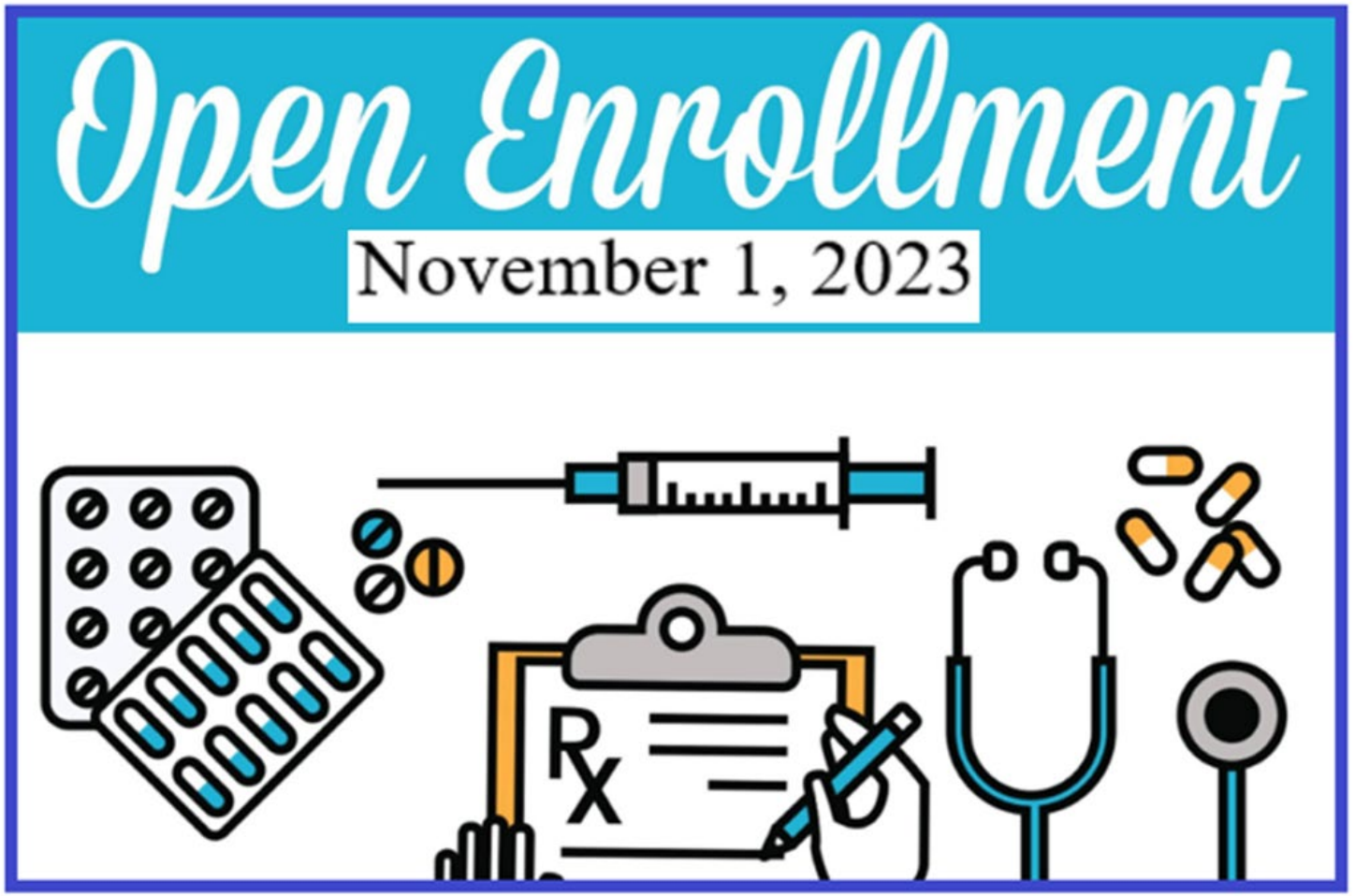


Provider Search

- Step 5: Review or change search criteria including:
- Plan
- Provider
- Location
- Mileage
- Provider Type
- Expanding/Searching Map



Get Ready!!



Who is eligible to enroll?

- **Any individual residing in one of Community's 20 county service area and their eligible dependents**
- Eligible dependents include:
  - Spouse
  - Biological children under the age of 26
  - Stepchildren under the age of 26
  - Adopted children under the age of 26
  - Foster children under the age of 26
  - Brother or Sister (child only policies)
  - Life partner

  (children up to age 26 are covered through the end of the year)

- **Families with more than 3 children enrolled on the same policy under the age of 21 are charged for the first three children only.** Children age bands include: 0-14, 15, 16, 17, 18, 19, 20
  - e.g., Family enrollment received:
    - Father – charged applicable rate for age band
    - Mother – charged applicable rate for age band
    - Child age 10 – charged 0-14 rate
    - Child age 6 – charged 0-14 rate
    - Child age 4 – charged 0-14 rate
    - Child age 2 – no charge

On Exchange -

- On Exchange enrollment can be completed through your Agent Portal, via www.Healthcare.gov direct or by phone at 1.800.318.2596
- Enrolling On Exchange is the only way a person can get **A**dvance **P**remium **T**ax **C**redits to help pay for their premiums
- Individuals receiving tax credits **MUST** file an income tax return
- On Exchange plans include the Cost Sharing Reduction plans (CSR plans) – Silver 73%, Silver 87%, and Silver 94% (cannot get Off Exchange)
- On Exchange plans also include Zero and Limited Cost Sharing plans available to members of federally recognized tribes or Alaska Native Settlement Act Corporation shareholders (cannot get Off Exchange)

Off Exchange

- Off Exchange plans are the same as the On Exchange standard Bronze, Silver, and Gold plans
- No CSR (73/87/94) or Limited/Zero Cost Sharing plans are available Off Exchange
- Apply through fax in a paper application that is available online
- Open Enrollment dates are the same as On Exchange and Special Enrollment Period criteria is the same as On Exchange
- Account servicing (including change of information, adding dependents, etc.) will go through Community, not CMS

Renewals Notice

- Community members currently enrolled in a plan will receive two notices regarding coverage:

  1. One from Community outlining premiums and benefit changes
  2. One from CMS explaining the open enrollment process

- If a current member takes no action, the member will "passively renew" into a 2024 Community plan

- Off-Exchange: A passive enrollment will **NOT** be generated for enrollments after 10/01/23. You will need to **actively** enroll members for 2024.

- Members currently enrolled in a plan that will be discontinued in 2023 will be "passively enrolled" into a respective new plan (See Plan Crosswalk slide)

- If a current member acts and updates their application on Healthcare.gov then they will need to select a 2024 plan

Special Enrollment Period (SEP)
Outside of Annual Open Enrollment

Consumers may qualify based on the following:

1. Loss of qualifying health coverage
2. Change in household size or income
3. Change in primary place of living
4. Loss of CHIP or Medicaid coverage
5. Change in eligibility for Marketplace coverage or help paying for coverage
6. Enrollment or plan error
7. Other qualifying changes: https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

- Once the application is created, the consumer will receive a request to submit supporting SEP paperwork within 30 days of the date of application. If paperwork is not received within that time frame the application will be terminated. The consumer will be mailed a notification indicating paperwork was not received timely and that the application has been terminated.

- Community will continue to pay commissions for SEP enrollments

Reminders for Brokers

- Acknowledgement that enrollment may affect taxes next year and that tax filing is required when receiving APTC
- Civil money penalties for provision of false information to the Marketplace: 45 C.F.R. §§155.220(k)(1)(ii) and 155.285
- Other state regulations:
  - 28 TAC§ 21.104 – Requirement of Identification of Policy or Insurer
  - 28 TAC§ 21.105 – Description of Benefits, Coverage, and Policy Provisions
  - 28 TAC§ 21.112 – General Prohibition
  - 28 TAC§ 21.121 – Lead Solicitations

Policy Updates

When a policy update is needed, please edit the existing application versus submitting a new application

Examples:

- Adding dependents
- Removing dependents
- Updating income
- Updating demographics

CMS Guidance- Subscriber ID Inheritance Issue Guidance

- MP/CMS- FFM reported post OE a large increase of "Subscriber ID Inheritance Issues" (Training held July 11, 2023)

What does that mean?

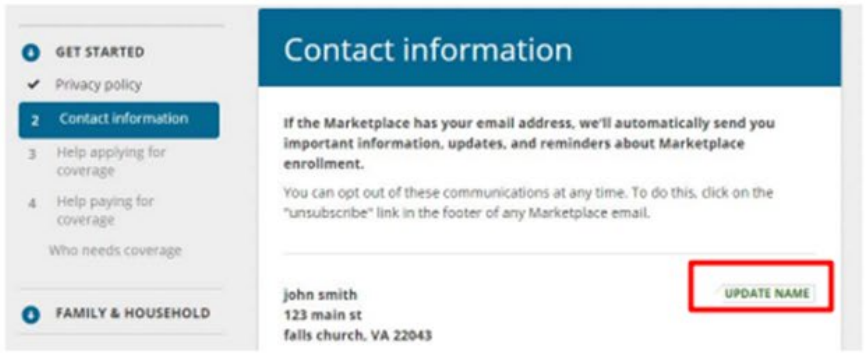
- Incident tickets processed regarding the reassignment of the Exchange-assigned Subscriber ID to a spouse or dependent who becomes the subscriber on a given account

- **In other words, it appears that two different people are sharing the same Exchange-assigned ID across different periods of time**

Example:

- Family enrolled with husband as the subscriber (sent with Exchange- assigned ID 0000000123) and wife as a dependent (sent with Exchange-assigned ID 0000000456)
- The husband ages into Medicare and attempts to terminate himself from the policy but retain coverage for his wife on the same application
- An enrollment (M834) is generated with the wife's information under the husband's Exchange-assigned ID of 0000000123 and the removal of dependent 0000000456

CMS Guidance- Subscriber ID Inheritance Issue Guidance- Continued



Best Practices & Tips for Prevention of Inheritance Issues

- Consumers should not end their Marketplace plan until they know for sure when their new coverage starts, and they should end their Marketplace plan the day their Medicare coverage begins to ensure that all other members on the policy maintain their current coverage.

- If Subscriber on the policy is ending coverage, then they should call or go online to request a termination date of the last day before the new coverage begins to ensure no one on the policy has overlapping Marketplace coverage when the Medicare coverage begins.

- Consumers should immediately end Marketplace coverage with APTC for anyone in the household who is determined eligible for full-benefit Medicaid or CHIP that is considered MEC, but they should not do so until they get a final decision from the Medicaid or CHIP agency.

Best Practices & Tips for Prevention of Inheritance Issues

- If they are found ineligible for full-benefit Medicaid or CHIP after terminating Marketplace coverage with APTC, they will not be able to re-enroll in the Marketplace until the next OEP unless they qualify for an SEP due to another qualifying life event.
- Do not assume that the Marketplace has an automated process in place to end coverage when consumers become eligible for Medicaid or Medicare.
- Do not contact the issuer instead of the Marketplace to request termination of coverage.

FAQ's

- Newborns must be added to a policy to have active coverage
  - If on-exchange newborn should be added with HC.gov
  - If off-exchange newborn should be added with Community
- Cancellations/terminations require written documentation signed by the member (preferably an application change/term form)
- PCP changes are effective first of the following month
- To provide specific claims information, your client must complete a HIPAA authorization form allowing you access
- Child only policies or policies where an individual other than the subscriber wants to be authorized for policy inquiries must have an HIPAA authorization form on file

Reminder

- **November 1, 2023:**
  Open Enrollment starts
- **December 15, 2023:**
  Enroll by this date for coverage starting January 1, 2024:
- **January 15, 2024:**
  Open Enrollment ends

Reminder: Health Coverage will begin February 1, 2024 if enrolled December 16th – January 15th

Next Steps

- **Post Training -** all agents will complete the 2024 Benefit quiz and return the completed 2024 Broker Training Attestation form along with any other require documents.
- As a sub-agent, please be sure to enter the Agency name in the required field on the quiz
- Submit all required documents back to Agent Credentialing Department at Agent.Credentialing@communityhealthchoice.org.
- Please make sure that your NAME and NPN matches on all documents submitted
- Complete required CMS 2024 Agent Training via the Marketplace Learning Management System (MLMS) or other CMS approved vendor

Questions

THANK YOU FOR YOUR PARTICIPATION!

COMMUNITY HEALTH CHOICE
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