2025 Access to Care Health Plan (ACHP)
Member Handbook
State Mandated Plan

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Welcome to Access to Care Health Plan (ACHP)!

Dear Member,

Thank you for choosing Access to Care Health Plan (ACHP) for your healthcare coverage! To get the most from your ACHP Plan, please read the entire ACHP Handbook. For a complete explanation of your health care coverage please refer to your Evidence of Coverage (EOC), Summary of Benefits in Coverage (SBC), and Schedule of Coverage (SOC) which will answer many of your questions in detail. You can find your EOC, SBC, and the SOC on our website at www.accesstocarehealth.com. The information in this handbook will help answer most of your questions including those related to:

- Your health care benefits
- How you and your family can receive health care services from in-network providers, within your health benefits plan network
- Your rights and responsibilities
- ACHP procedures

ACHP is committed to meeting the needs of our members and providing services to people of all cultures, races, ages, ethnicities, religious backgrounds and disabilities with the upmost respect, dignity, and accountability for you, our valued member. Our values communicate not just who we are, but also our commitment to meeting the needs of our members and community.

ACHP Values

- Integrity
- Diversity & Inclusion
- Efficiency
- Accountability
- Local
- Service

Access to Care Health Plan is a nonprofit, community-based subsidiary of the Travis County Healthcare District (d.b.a. Central Health). ACHP is a health maintenance organization (HMO) that provides benefits to eligible members who reside, live or work

in Travis Service Area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties. As part of your benefits package, ACHP has in-network providers and facilities to deliver the healthcare treatment you need. You must reside, live or work within the service area to be eligible for healthcare coverage with ACHP.

Important Information

Call Us:	Member Services: Toll Free: 1-844-800-4693 For Hearing Impaired (TTY): 7-1-1
Write Us:	Access to Care Health Plan 2028 E. Ben White Blvd., Suite 400 Austin, TX 78741
Business Hours:	Monday through Friday 8:00 AM – 5:00 PM CST
After hours	If you call before or after hours, leave a voice message. We will return your call the next business day.
Suicide & Crisis Help Line 988Lifeline.org	9-8-8
24/7 Virtual Urgent Care	24/7 Virtual Urgent Care is available to all ACHP members 24 hours a day, 7 days a week at no additional cost. For more information, call 1-844-800-4693.
Vision and Eye Care Number: Envolve Benefit Options	Call 1-855-279-9680 for information about vision benefits and services available to Members under the age of 21.
Pharmacy Line: Navitus Health Solutions	Call 1-866-333-2757 for information about medication and pharmacy benefits.
Pediatric Dental Line: LIBERTY Dental	Call 1-866-609-0426 for information about dental benefits available to Members under the age of 19.

Figure: 28 TAC §11.1612(c)

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.
If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.
You can get the directory online at www.accesstocarehealth.com by calling 1-844-800-4693.
If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of- network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in- network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at tdi.texas.gov.

Benefits/Covered Services

To receive the benefits as indicated in your Evidence of Coverage (EOC) and Summary of Benefits and Coverage (SBC) you must choose an In-Network Provider, within your health benefits plan network, to provide your care (other than emergency care and emergency transportation).

ACHP's network includes physicians, specialty providers, urgent care facilities and hospitals.

Please consult your EOC and the SBC for a listing of benefits, covered services, limitations and exclusions. If you need help understanding your EOC, SBC or to inquire if a certain service is covered or requires preauthorization, call Customer Service toll-free at 1-844-800-4693 for assistance.

Below is an example of an SBC that provides details about covered services, co-pays and exclusions.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services — Coverage Period: 01/01/2025 – 12/31/2025
Access to Care Health Plan: Platinum Off Exchange — **Coverage for: Individual, Individual + Spouse, Family | Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at 1-844-800-4693 or visit us at www.https://accesstocarehealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.https://www.healthcare.gov/sbc-glossary or call 1-844-800-4693 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/Individual or $0/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$4,900/Individual or $9,800/Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. accesstocarehealth.com or call 1-844-800-4693 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you

Your covered services include but are not limited to:

- preventive care visits
- maternity care
- behavioral health
- vision care
- prescription drugs
- emergency care
- durable medical equipment (DME)
- dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases
- amino–acid bases elemental formulas
- acquired brain injury treatment
- treatment for Autism Spectrum Disorder
- diabetes equipment and supplies
- benefits for routine patient costs for members in certain clinical trials.

Some of your covered services require that you pay a copay. A copay is a fixed amount you pay for a covered health care service.

Certain covered services require preauthorization before receiving the service. If a service requires preauthorization, and ACHP does not authorize it, the service(s) provided will be denied.

Please note: The application of a deductible and coinsurance only applies to Consumer Choice health benefit plans and does not apply to State Mandated health benefit plans.

In-Network versus Out of Network

Your ACHP Plan is a network-based plan. The network provides you access to facilities, primary care, and specialty providers within your health benefits package and the ACHP service area. To find out what network pertains to the plan you are enrolled in, please visit: www.accesstocarehealth.com or call Customer Service at 1-844-800-4693.

In-network providers agree to ACHP's standards, processes, and fee schedules. In addition, in-network providers agree not to balance bill ACHP members for any unpaid amounts for services rendered other than co-payment (s) amounts. ACHP providers are located within Travis Service Area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties.

Likewise, if you need to see a specialist or visit a facility, your primary care provider can assist you by requesting a referral or preauthorization so you can receive treatment and/ or care from an in-network specialist or facility within your health benefits plan package. By seeing an in-network provider, specialist, or facility within your health benefits plan

network, you will keep your out-of-pocket expenses to a minimum. To see a list of the ACHP Plan in-network providers, specialists, and facilities within your health benefits plan network, visit www.accesstocarehealth.com.
Out-of-network providers are not contracted to provide services for ACHP members, with the exception of assessment and stabilization for Emergency Care. The ACHP Plan excludes coverage for services rendered by an out-of-network provider, and you may be balance billed for these services.

Out of network referrals when covered medically necessary services are not available through network physicians or providers, can be requested. However, please note that non-emergency services provided by an out-of-network provider, which are not preauthorized by ACHP, are excluded from coverage. The total charges from an out-of-network provider for non-emergency services are the complete and full responsibility of the ACHP member.

Maternity Services

Maternity services include prenatal care, delivery, postnatal treatment, and pregnancy complications.

Prenatal and postnatal care are covered benefits. Any blood work, ultrasound, genetic testing and/ or any other medical service requested or provided by your doctor may be subject to a copay amount.

Vaginal Delivery includes the first 48 hours of care for the mother and newborn.
Cesarean Section Delivery includes the first 96 hours of care for the mother and newborn.

Except for emergency care, out-of-network prenatal, postnatal care, delivery, and inpatient services are not covered benefits without ACHP's prior approval for out-of-network services.

Behavioral Health

If an ACHP member, including dependents, need treatment for a mental or emotional disorder, or has a problem with drugs or chemical dependency disorders call ACHP at 1-844-800-4693. The ACHP network includes mental health and substance abuse professionals who can help. Some substance abuse or mental health problems, such as severe depression, may require urgent care. You may schedule an appointment with an in-network behavioral health provider. You do not need a referral from your PCP for

behavioral health treatment as long as the behavioral health provider is within your health benefits plan network.

Preventive Health Services

ACHP wants you to stay healthy and detect any problems as early as possible. Certain preventive health services are covered without cost sharing. These services must be provided by in-network providers.

The full list of covered preventive services is available in your ACHP *Evidence of Coverage* document located on www.accesstocarehealth.com. A summary of these are listed below:

- Routine physical examinations
- Routine immunizations
- Well-baby and well-child care
- Well-woman examinations
- Screenings for:
    - Abdominal aortic aneurysm
    - Abnormal blood pressure
    - Alcohol misuse
    - Anemia
    - Autism
    - Certain cancers (breast, cervical, colorectal, lung, prostate)
    - Cardiovascular disease
    - Cervical and ovarian cancer
    - Childhood vision screenings
    - Depression
    - Diabetes and gestational diabetes
    - Domestic/interpersonal violence
    - Hearing and/or sight problems
    - Hepatitis
    - Cholesterol
    - HIV (human immunodeficiency virus)

- Obesity
- Oral health
- Osteoporosis/bone density
- Preeclampsia
- RH incompatibility
- Routine newborn screenings
- Routine childhood developmental screenings
- Sexually transmitted disease (Chlamydia, Gonorrhea, HPV, Syphilis)
- Tobacco use
- Tuberculosis
- Urinary tract infection during pregnancy

- Counseling for
    - Alcohol misuse
    - Breast cancer genetic testing and chemoprevention
    - Breast feeding
    - Nutrition/diet
    - Obesity
    - Quitting smoking
  - Certain medications or treatments
  - Contraception
  - Fluoride prevention supplements
  - Fluoride varnish
  - Folic acid supplements
  - HIV prevention (pre-exposure)
  - Iron supplements
  - Statins
  - Tobacco cessation interventions

Dental Services

Routine dental services, including an annual dental exam, are covered benefits, only for:

a. Covered Oral Surgery;

b. Pediatric Members Pediatric dental coverage is available to members up to the age of 19 (coverage will end on the last day of the month in which the Member turns 19).

Except as specified immediately above, Dental services are not provided except for:

a. care or treatment due to an external, accidental injury to sound natural teeth and supporting tissue, or

b. dental care or treatment provided to a newborn child which are necessary to correct or treat a congenital defect, disease or anomaly.

ACHP will limit Covered Services to the least expensive service that we determine will produce professionally adequate results. Cost sharing and limitations depend on type and site of service.

Prescription Drugs (Formulary Drugs)

ACHP maintains a formulary list that tells you which medications are generic, preferred and non-preferred. A copy of the current list can be obtained by calling a Customer Service representative, who can answer questions about your copayments. The ACHP Plan Formulary is also posted on the ACHP Plan website at www.accesstocarehealth.com. Please note that over-the-counter medications are not a covered benefit and some prescribed medications require prior authorization.

There is little difference between a brand name drug and the generic version. Generic drugs have the same active ingredients as brand name drugs and are less costly. They may be a different color and shape. Your pharmacy will fill your prescription with a generic drug if it is available. The United States Food and Drug Administration (FDA) requires generic drugs to have the same high quality, strength, purity and stability as brand-name drugs. If your provider does not want a generic substitution, he or she must contact us and tell us the reason. If we do not approve the request, you and/or your provider will be informed of our decision. You have the right to request an appeal if the request is not approved. We will tell you how to do this when we give you or your provider our decision.

For some drugs, our approval is required this is called prior authorization. If your provider decides that you should take a drug in this group, he or she will contact us to receive authorization before giving you a prescription for the drug. Your provider must complete a prior authorization form and send it to us so that a decision about coverage can be reached. After the request is reviewed, you and/or your provider will be informed

of our decision. If we approve the drug, you may obtain it from a participating pharmacy. If we do not approve the request, you and/or your provider will be informed of our decision. You have the right to request an appeal if the request is not approved. We will tell you how to do this when we give you our decision.

You have different coverage levels, depending on what 'tier' drug you your drug is assigned to on the ACHP Plan pharmacy formulary. With a five-level drug benefit, your prescription medications fall into one of the five categories or 'tiers'. Each tier has a different copay or coinsurance. Refer to your Summary of Benefits and Coverage and your Evidence of Coverage for additional details or contact Customer Service toll-free at 1-844-800-4693.

Some drugs require step therapy. This means that you must try a first step drug before the second step drug will be covered. Usually generic drugs are in the first step.

ACHP prohibits step therapy for prescription drugs used to treat stage four-advanced metastatic cancer. This prohibition only applies to an FDA-approved drug when its use is consistent with best practices for the treatment of stage four-advanced metastatic cancer or an associated condition and is supported by peer-reviewed, evidence-based literature.

You may be asked to take a drug that is chemically different from the drug originally prescribed. This different drug will have the same therapeutic purpose and will be used for the same FDA approved conditions. This is called "Therapeutic Interchange". The pharmacist or your prescriber may ask you to take this drug and will explain the reasons why he or she believes this is a better drug choice for you. You do not have to agree. If you do not agree, your original drug prescription will be filled.

- Tier 1- Preventative care drugs for qualified enrollees; Zero out of pocket cost.
- Tier 2 – Most affordable drugs which include generics and select brand drugs; lowest out of pocket cost.
- Tier 3 – Preferred drugs have been proven to be effective and may be favorably priced compared to other drugs that treat the same condition; Middle-level out of pocket cost.
- Tier 4 – Non-preferred drugs have not been found to be any more cost effective than available generics or preferred band; higher out of pocket cost.
- Tier 5 – Specialty Drug (SP) typically require special dispensing and have limited availability and patient populations; Highest out of pocket cost.
- Tier 6 –Medical Service drugs are drugs that may be covered under your medical benefit (Physician visit or hospital visit). Medical Service Drugs require administration by a clinician or in a facility. They are not dispensed through the outpatient pharmacy; this is not covered under ACHP.

Chronic Eye Disease eye drops, are dispensed at a 30/60/90-day supply. For more information, please contact the Customer Service Pharmacy Line at 1-844-800-4693. Mail order is available for ACHP members.

We encourage safe use of drugs by setting a maximum quantity per month for some drugs. These quantity limits are based on the FDA guidelines and the manufacturer's recommendations. There are circumstances that warrant exceptions to these limits. Your physician can request an exception by contacting us and telling us the reason for the exception. We will inform you about our decision. If we do not approve the request for an exception to the quantity limits, we inform your physician how to appeal the decision.

For more information about our pharmacy procedures and to see if a drug is included in our formulary go to www.accesstocarehealth.com. The formulary will tell you about:

- The drugs included in our formulary
- Quantity limits and copayments for drugs
- Restrictions that apply to drugs such as prior authorization requirements
- How to obtain prior authorization for a drug, if required
- How your physician may request an exception to our formulary, including the documentation that we require to review this request
- How you or your physician may appeal our decision not to approve the request for an exception.
- The process for generic substitution of drugs
- Step therapy requirements
- Therapeutic interchange requirements
- Any other requirements, restrictions, limitations, or incentives that apply to the use of certain drugs

To check on coverage for a specific drug, you can review our online formulary or call Customer Service if the drug you are taking is not listed in our formulary. You may ask that we cover the drug by making an exception request. Your physician will need to tell us the reasons why he or she believes we should make an exception to our formulary.

If you need to request a Medication Exception, any of the following people can request a coverage determination:

- You, the member.
- Your doctor may ask us for a coverage determination for you or

- Your representative (family member or friend that has been identified as your representative).

Requests need to be submitted to Navitus Health Solutions, (ACHP's Pharmacy Benefits Manager). You can ask for two kinds of determination:

- Standard Request- Are requests that are not urgent. The turnaround time to receive a response to your request is 72 hours following receipt of the request.
- Expedited Requests- Urgent is defined as: There is an imminent and serious threat to your health. The turnaround time to receive a response to your request is 24 hours following receipt of the request.

Requests can be made orally or in writing. If you want to submit your request in writing, use the Model Coverage Determination Request Form found on the Navitus Benefits Member Portal. You or your doctor can fill the form out and fax it to 1-855-668-8551 or log in to the Pharmacy Benefits Member Portal and submit the form electronically. If you need help initiating the process for Medication Exception, please call Navitus Toll free 1-866-333-2757.

Using Your Formulary Benefits

You can get your prescription filled by presenting your ACHP ID Card at any in-network pharmacy. ACHP also has a Prescription Drug Portal available on our website that will help you find a pharmacy close to you, confirm your copay for your prescription(s), and provide additional information about your medications.

When showing your ACHP ID Card to the pharmacists, you are providing them with all the information they need to fill your prescription. The pharmacist will ask you to pay for the copayment amounts for your prescription. You are not required to make a payment for a prescription drug that is more than the lesser of your copayment, the allowable claim amount, or the amount you would pay if purchasing the prescription without health benefits or discounts. If you have any questions about your prescription, ask the pharmacist.

Emergency Care

Emergency Care includes those health care services you receive in a hospital emergency room or comparable facility to evaluate and stabilize certain medical conditions including behavioral health conditions. These conditions are of a recent onset and severity (such as severe pain) that would lead a person with average knowledge of medicine and health to believe that the person's condition, sickness or injury is such that failure to get immediate medical care could cause the following:

- Placing your health in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

In addition, here is a limited list of situations that would also be considered medical emergencies. If you believe you have a medical emergency go to the closest emergency room or call 9-1-1. Emergencies include but are not limited to:

- Apparent heart attack
- Loss of consciousness
- Chest pain with symptoms of heart attack
- Stroke
- Poisoning
- Severe bleeding
- Convulsions
- Fractures
- Severe abdominal pain of sudden onset
- Severe injuries or trauma
- Shock from sudden illness or injury
- Difficulty in breathing, such as in a severe asthma attack

If you are having an emergency and need care immediately, go to the nearest emergency room or call 9-1-1.

If you're not sure how urgent your symptoms are, you can access the 24/7 Virtual Urgent Care Service through NormanMD at no additional cost for immediate medical advice. You can register for the service online at: www.accesstocarehealth.com/telemedicine

If you receive Emergency Services at an In-Network Facility and you receive a balance bill from a non-network facility-based physician, or other health care practitioner for Emergency Services, please contact Member Services at 1-844-800-4693. ACHP will fully reimburse the non-network facility-based physician or provider at the usual and customary or agreed upon rate. You should not be balance billed for Emergency Services. You may be required to submit a copy of the itemized billing statement for investigation purposes. ACHP will work to hold you harmless for any amounts beyond the copayment or other out-of-pocket amounts that you would have paid had ACHP's network included network physicians or providers from whom you could obtain emergency services. ACHP will hold you harmless when a non-network facility-based physician renders services to you in a network facility.

Out of the Area Emergency Care

Emergency care services are covered in-network and out-of-network. Necessary Emergency Care Services will be provided to you including treatment, stabilization of a medical condition, medical screening examination, or other evaluation required by state or federal laws.

If, after an evaluation, emergency treatment is determined not necessary, you must contact your PCP to arrange any non-emergency care needed. If you choose to use the emergency room for non-emergency treatment, you will be responsible for all billed charges. You must contact your PCP for follow-up care.

If the emergency physician refers you to a specialist, you must follow-up with your PCP prior to seeing a specialist. You or someone acting on your behalf should contact your PCP within 24-hours or as soon as reasonably possible to arrange for follow-up care after being discharged from the emergency room.

If you need Emergency Services, while outside of the ACHP Service Area, go to a nearby hospital and call Customer Service at 1-844-800-4693.

If you receive Emergency Services and are balance billed by a non-network facility, physician, or other health care practitioner, please contact Member Services at 1-844-800-4693. ACHP will fully reimburse the non- network facility, physician or other healthcare provider at the usual and customary or agreed upon rate. You should not be balance billed for Emergency Services. You may be required to submit a copy of the itemized billing statement for investigation purposes.

How To Obtain Care After Normal Office Hours

If you are sick, have a severe injury that needs an assessment and / or treatment at night, or on the weekend, you can contact your PCP. Your PCP will advise you of the steps you can take to seek care based on your symptoms. Your PCP may be available directly or will arrange to assist you with another provider 24 hours, 7 days a week.

ACHP offers all members 24/7 Virtual Urgent Care at no additional cost. You can register for the service online at: www.accesstocarehealth.com.

If a covered person receives covered services as telemedicine medical services, telehealth, and / or teledentistry from an in-network Healthcare Practitioner, coverage for these services are the same as seeing a Healthcare Practitioner in an in-person

setting. There is not a separate annual maximum, or lifetime maximum for covered services delivered as telemedicine medical services or telehealth services.

Urgent Care

An urgent care situation is not as serious as an emergency. Urgent care includes services other than those for an emergency that result from an acute injury or illness that is severe or painful enough to lead a person to believe failure to get treatment within 24 hours would cause serious deterioration of his or her health.

Examples of Urgent Care conditions are

- Abdominal pain
- Allergic reactions that are not severe, such as itching, rash or hives
- Cold or Flu symptoms that are not severe
- Cough that persists
- Cuts and scrapes
- Diaper rash
- Earache
- Fainting
- Insect bites and rashes
- Low-grade fever with no rash
- Minor or moderate accidents
- Repeated diarrhea or vomiting
- Sprains
- Urinary tract infection

If you are within the ACHP Plan service area and cannot reach your PCP, you may call Customer Service toll-free at 1-844-800-4693. Customer Service can assist you with finding an in-network urgent care center, within your health benefits plan network.

Traveling Out Of the Service Area

When you plan to be out of the ACHP Service area, contact your primary care physician (PCP) ahead of time to schedule appointments, or obtain prescriptions to last the duration of your time away.

ACHP does not cover non-emergency services when you are out of the ACHP service area. If you receive non-emergency services out of the service area, you will be responsible to pay for the balance due to the facility or provider.

If you need Emergency Services, while outside of the ACHP Service Area, go to a nearby hospital and call Customer Service at 1-844-800-4693. If you receive Emergency Services and are balance billed by a non-network facility, physician, or other health care practitioner, please contact Member Services at 1-844-800-4693. ACHP will fully reimburse the non- network facility, physician or other healthcare provider at the usual and customary or agreed upon rate. You should not be balance billed for Emergency Services. You may be required to submit a copy of the itemized billing statement for investigation purposes.

Hospital Services

When you require hospitalization, your PCP or specialist will refer you to an in-network hospital. Your PCP and ACHP's Medical Management staff will also assist you with coordinating your care throughout your hospital stay.

Please verify that the hospital you are being referred to is within your health benefits plan network. Member Services can assist you with verifying if the hospital is in your plan network. Member Services is available Monday – Friday from 8:00 am to 5:00 pm at 1-844-800-4693.

Balance Billing

If you receive care at an in-network hospital, within your health benefits plan network, there is a possibility that some of the hospital-based providers are not in-network with ACHP. Some examples of hospital-based providers are anesthesiologist, radiologist, pathologist, an emergency department physician, a neonatologist, or an assistant surgeon. This also includes non-network diagnostic imaging and laboratory service providers. These providers may bill you for the difference between ACHP's allowed amount and the providers billed charge. When a provider bills you for the difference this is called balance billing.

If you receive a balance bill, you should contact ACHP at 1-844-800-4693. You should not be balance billed for Emergency Services. You may be required to submit a copy of the itemized billing statement for investigation purposes.

Payment for Service and Claims

You are responsible for your copayment(s) and coinsurance, if applicable, at the time services are rendered. Other than your cost share, you should not receive a bill for

covered services from an in-network provider, within your health benefits plan network. If you think you received a bill in error, please call Customer Service toll-free at 1-844-800-4693 for assistance.

To help assist the provider with submitting claims timely to ACHP, **please provide your plan coverage information as soon as possible and respond to any correspondence sent to you by the provider**.

You *may* be responsible for billed charges if your claim is not submitted to ACHP within 95 days from the date of service.

Explanation of Benefits (EOB)

An EOB is a statement that ACHP generates that summarizes the cost of the healthcare services you have received. An EOB shows how much your health care provider is charging us, if ACHP issued payment and how much you may be responsible for paying. You can access your EOB by logging into the Member Portal.

If you need assistance accessing your EOB or would like a copy mailed to you, please contact our Customer Service Department at 1-844-800-4693.

Medical Limitations and Exclusions

As described in the Evidence of Coverage (EOC), some benefits are not available for:

- Services provided by a non-participating provider, except when:
    - Pre-authorized by ACHP or
    - delivered in an emergency situation:
        - Services in a hospital emergency room, freestanding emergency medical care facility or comparable emergency facility
        - Services delivered when the Member, in connection with a medical emergency, is being transported to the nearest acute care hospital equipped to treat the member's condition.
- Services incurred before the Effective Date or after the termination date of this EOC/Contract;
- Services not Medically Necessary to prevent, alleviate, cure or heal Bodily Injury or Illness, except for the specified routine Preventive Services;
- Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract.
- Any services or supplies provided for injuries sustained:
    a. As a result of war, declared or undeclared, or any act of war; or

b. While engaging in an illegal occupation;
c. While engaging in any act of armed conflict, or any conflict involving armed forces or any authority;
d. While on active or reserve duty in the armed forces of any country or international authority.

- Services received for any condition caused by a Member's commission of, or attempt to commit an illegal act, are excluded from coverage.
- Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any charges resulting from the failure to keep a scheduled visit with a Healthcare Practitioner or other Provider; or for completion of any plan coverage forms; or for acquisition of medical records.
- Complications directly related to a service that is not an EOC/Covered Service under this Contract because it was determined by us to be Experimental or Investigational or not Medically Necessary, except as expressly provided in this Contract.
- Services exceeding the amount of benefits available for a particular service;
- Services for, or the treatment of complications of, non-covered procedures or services or any plan aggregate limits;
- Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred as a result of the Covered Member.
- Services relating to an Illness or Bodily Injury as a result of:
    - For which no charge is made, or for which the Covered Member would not be required to pay if he/she did not have this coverage, unless charges are received from and reimbursable to the United States government, or any of its agencies as required by law;
    - Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law which You or the Covered Member is not legally obligated to pay;
    - Furnished while a Covered Member is Confined in a Hospital or institution owned or operated by the United States government or any of its agencies for any service-connected illness or Bodily Injury;
    - Which are not rendered or not substantiated in the medical records;
    - Provided by a Family Member or person who resides with the Covered Member;
    - Performed in association with a non-covered service.
    - Hospital Inpatient Services when the Covered Member is in Observation Status;

    - Except as otherwise provided in this Contract, cosmetic services, or any complication here from;
    - Custodial care and Maintenance Care;
- Private duty nursing except when medically necessary and for covered Extended Care Expenses
- Non-ambulance transport, such as wheelchair van, except as explicitly provided elsewhere in this Contract or at the discretion of ACHP through a discretionary program
- Ambulance services used because they are more convenient for the patient than another mode of transportation, whether or not recommended by a Physician or Other Professional Provider
- Elective medical or surgical abortion unless:
    - An abortion is performed due to a medical emergency. For purposes of this section, medical emergency means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
- Any services or supplies provided for, in preparation for, or in conjunction with: Infertility Treatment;
    - Sterilization reversal (male or female);
    - Transsexual surgery or sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;
    - Sexual dysfunction;
    - In vitro fertilization
- Promotion of fertility through extra- coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans- uterine tubal insemination, gamete intra-fallopian transfer (GIFT), pronuclear oocyte stage transfer, zygote intra-fallopian transfer, tubal ovum transfer, and tubal embryo transfer; and
- Embryo freezing or transfer;
- Sperm storage or banking;
- Ovum storage or banking;
- Embryo or zygote banking;
- Any services or supplies provided for reduction mammoplasty
- Adult 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 (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this Contract;
- Child radial keratotomy; refractive keratoplasty; or any other Surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises);
- Non-Pediatric dental services, including, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of

partially or completely un-erupted impacted teeth, any oral or periodontal Surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a Bodily Injury or Illness except as expressly provided in this Contract;

- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Any items of Medical-Surgical Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the Benefits for Dental Services provision in this Benefit Booklet
- Pre-surgical/procedural testing duplicated during a Hospital Confinement;
- Any treatment for obesity, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    - Bariatric surgery, procedures, or treatment(s);
    - Other surgical procedures for Morbid Obesity;
    - Services or procedures for the purpose of treating an Illness or Bodily Injury caused by, complicated by, or exacerbated by the obesity; or
    - Complications related to any services rendered for weight reduction;
    - Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery;
- Routine eye care for adults, other than what is covered under “Diabetes Services” above or otherwise expressly provided in this Contract.
- Routine Foot Care for Standardized Plans
- Foot care services, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, including but not limited to:
    - Shock wave therapy of the feet;
    - Treatment of Weak, strained, flat, unstable or unbalanced feet;
    - Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    - Tarsalgia, metatarsalgia or bunion treatment, except Surgery which involves exposure of bones, tendons or ligaments;
    - Cutting of toenails, except removal of nail matrix; and
    - Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless Medically Necessary because of diabetes circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, chronic arterial or venous insufficiency, or hammertoe; unless otherwise indicated
- Hair prosthesis, hair transplants or implants; except for wigs after cancer treatment, as expressly provided in this Contract under Durable Medical Equipment/Prosthetics/Orthotics);
- Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician or Provider in a non-facility setting or purchased “over the counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-

made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

    a. Note: this exclusion does not apply to podiatric appliances when provided as Diabetic

- Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant. Hearing care that is routine, including but not limited to exams and tests, any artificial hearing device, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided in this Contract;
- Transplant services except as expressly provided in this Contract;
- “Over the counter” medical items or supplies that are available without a written order or Prescription, except for those Benefits expressly provided in this Contract as Preventive Services;
- Immunizations including those required for foreign travel for Covered Persons of any age except as expressly provided in this Contract;
- Expense for employment, school, sports or camp physical examinations or, for the purpose of obtaining insurance, premarital tests/examinations; Physical Therapy or other expenses for the purpose of improving sports performance.
- Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under benefits for Autism expressly provided in this Contract.
- Services received in an emergency room unless Emergency Care;
- Observation Status stays longer than 48 hours
- Room and board charges incurred during a Hospital Admission for diagnostic or evaluation purposes unless the test(s) could not have been performed on an outpatient basis without adversely affecting the Member’s physical condition or the quality of medical care provided
- Any Expense Incurred for services received outside of the United States except for Emergency Care services;
- Any Expenses for complications of services received outside of the United States, except for Emergency Services
- Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders
- Services and supplies which are:
    - Rendered in connection with mental Illnesses not classified in the current Diagnostic and Statistical Manual of Mental Disorders;
    - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation; and
    - For the purpose of medical social services, bereavement counseling, vocational counseling, or marriage and family therapy, except as specifically included in covered expenses

- For the purpose of medical social services, bereavement counseling, vocational counseling, or marriage and family therapy, except as specifically included in covered expenses
- Immunotherapy for recurrent miscarriage;
- Home uterine activity monitoring;
- Sleep therapy;
- Light treatment for Seasonal Affective Disorder (S.A.D.);
- Immunotherapy for food allergy;
- Prolotherapy;
- Cranial banding;
- Hyperhidrosis Surgery; and
- Sensory integration therapy;
- Charges for alternative medicine, including medical diagnosis, treatment and therapy.
- Alternative medicine services include, but is not limited to:
    - Acupressure;
    - Acupuncture;
    - Aromatherapy;
    - Ayurveda;
    - Biofeedback (except to the extent it includes Neurofeedback Therapy that is Medically Necessary for the treatment of an Acquired Brain Injury);
    - Faith healing;
    - Guided mental imagery;
    - Herbal medicine;
    - Holistic medicine;
    - Homeopathy;
    - Hypnosis;
    - Macrobiotic diet prescriptions;
    - Massage therapy;
    - Naturopathy;
    - Ozone therapy;
    - Reflexology;
    - Relaxation response;
    - Rolfing;
    - Shiatsu; and
    - Yoga;
- Living expenses;
- travel;
- transportation, except as expressly provided in the Emergency and Ambulance services provision or Transplants provision in the Your Contract Benefits section of this Contract; and

- Charges for services that are primarily and customarily used for a non- medical purpose or used for environmental control or enhancement (whether or not prescribed by a Healthcare Practitioner) including but not limited to:
    - Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;
    - Scooters or motorized transportation equipment escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bedside commodes;
    - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    - Medical equipment that does not require a prescription, including blood pressure monitoring devices, PUVA lights and stethoscopes;
    - Charges for any membership fees or program fees paid by a Covered Member, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and Weight loss or similar programs and any related material or products related to these programs;
    - Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and
    - Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.
- Inpatient allergy testing or treatment
- Allergy serums and allergy testing materials
- Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.
- Legal Medicine Specialist or Services: The specialty areas of medicine concerned with matters of, and relations with, substantive law and legal institutions; such as the conduct of medical examinations at crime scenes, performance of autopsies, giving of expert medical testimony in judicial proceedings, medical treatment of inmates of penal institutions, and the practice of trauma medicine in law enforcement settings, and other clinical practice and medical science applications in the fields of law, law enforcement, and corrections.

Prescription Drug Exclusions

Except as expressly stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Drugs which are not included on the Drug Formulary;

2. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or certain other inherited metabolic diseases and amino acid based elemental formulas as expressly provided in this Contract;
3. Nutritional products;
4. Fluoride supplements except when prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride;
5. Minerals;
6. Herbs and vitamins;
7. Legend (prescription) drugs which are not deemed Medically Necessary by ACHP;
8. Any drug prescribed for any Illness or Bodily Injury for which services are not covered under this Contract;
9. Any drug prescribed for intended use other than for:
    a. Indications approved by the FDA; or
    b. Off-label indications recognized through peer-reviewed medical literature;
10. Any drug, medicine or medication that is either:
    a. Labeled "Caution-limited by Federal law to investigational use"; or
    b. Experimental or investigational, even though a charge is made to the Member;
11. Allergen extracts;
12. The administration of covered medication(s);
13. Therapeutic devices or appliances, except as expressly provided in this Contract, including but not limited to:
    a. Hypodermic needles and syringes except needles and syringes for use with insulin, and Self-Administered Injectable Drugs whose coverage is approved by ACHP;
    b. Support garments;
    c. Other non-medical substances;
14. Anorectic or any drug used for the purpose of Weight control;
15. Abortifacients (drugs used to induce abortions);
16. Any drug used for cosmetic purposes, including, but not limited to:
    a. Tretinoin, e.g. Retina, except if the Member is under the age of 35 or is diagnosed as having adult acne;
    b. Dermatologicals or hair growth stimulants;
    c. or Pigmenting or de-pigmenting agents, Solaquin;
17. Contrary to any other provisions of this Contract, ACHP may decline coverage or, if applicable, exclude from the Drug Formulary any and all drugs, including new indications for an existing drug, until the conclusion of a review period not to exceed (six) 6 months following FDA approval for the use and release of the drug, including new indications for an existing drug into the market;
18. Any drug or medicine that is:
    a. Lawfully obtainable without a Prescription (over the counter drugs), except insulin; or drugs, medicines or medications required as part of Healthcare reform with a Prescription from a Healthcare Practitioner;
    b. Available in Prescription strength without a Prescription;

19. Compounded estrogen, progesterone, and testosterone for hormone replacement therapy;
21. Oral and injectable infertility and fertility
22. Any drug prescribed for impotence and/or sexual dysfunction, e.g., Viagra
22. Drug delivery implants;
23. Prescriptions that are to be taken by or administered to the Member, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
    a. Hospital
    b. Skilled nursing facility or Sub-Acute Rehabilitation Facility; or
    c. Hospice facility;
24. Prescription refills:
    a. In excess of the number specified by the Healthcare Practitioner, or
    b. Dispensed more than one year from the date of the original order;
25. Any portion of a Specialty Drug or Self-Administered Injectable Drug that exceeds a 30- day supply;
26. Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained;
27. Any drug for which a charge is customarily not made;
28. Any portion of a Prescription or refill that:
    a. Exceeds our drug specific Dispensing Limit (e.g. IMITREX);
    b. ls dispensed to a Member whose age is outside the drug specific age limits defined by ACHP;
    c. ls refilled early, as defined by ACHP; or
    d. Exceeds the duration-specific Dispensing Limit;
29. Any drug, medicine or medication received by the Member:
    a. Before becoming covered under this benefit; or
    b. After the date the Member 's coverage under this Contract has ended;
30. Any costs related to the mailing, sending or delivery of Prescription Drugs;
31. Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Member;
32. Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

33. Any amount the Member paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription;

Refer to the Appeal Complaints and External Review provision in the General Provisions section in this Contract for more information.

Prior Authorization Requirements

Prior authorization lets ACHP know in advance that a specific care plan or service is needed for you. Your PCP or in-network treating provider is responsible for obtaining the necessary preauthorization. Preauthorization does not guarantee payment of

services if the physician or provider has materially misrepresented the proposed health care services or has substantially failed to perform the proposed health care services. Please confirm with your provider if the treatment or services are covered by ACHP and if an authorization is needed. The availability of benefits is subject to other ACHP requirements such as limitations and exclusions, payment of premium, and eligibility at the time of care and service.

ACHP's preauthorization program uses written, medically acceptable screening criteria, and procedures that are established and updated with input from in-network providers.

ACHP will notify your PCP or treating provider of the decision regarding the pre-authorization request no later than the third day after the date the request was received. If the preauthorization request is for concurrent hospitalization care, ACHP will notify your PCP or submitting provider within 24 hours after the request is received. If the preauthorization is for post-stabilization treatment or life-threatening conditions, ACHP will provide notification to your PCP or submitting provider no later than one hour after the request was received. If ACHP denies the service(s) we will provide written notification within three calendar days from the telephone or electronic transmission of the adverse determination. If the circumstance involves post-stabilization treatment or life-threatening conditions, ACHP will provide a response for the proposed services requested within the appropriate timeframe relating to the delivery of the services, and the condition of the member, but in no case to exceed one hour from receipt of the request. If ACHP receives a prior authorization request for services after the services have been rendered, the requested services will be denied for no prior authorization within three (3) calendar days from receipt of request.

Per HB3459, some physician or providers are not required to obtain preauthorization for a particular health care service if the physician or provider meets exemption criteria for certain health care services.

Continuity of Care

Continuity of care is important to your health. Continuity of care is concerned with quality of care over time. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care. If you are receiving treatment for a medical condition at the time your PCP and/or specialist leaves the ACHP network, you may be eligible to continue the treatment for a period of time with your treating provider regardless of the provider's network status.

Per Texas Insurance Code § 843.362. Continuity of Care; Obligation of Health Maintenance Organization

- In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that

physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or life-threatening illness, or who is past the 24th week of pregnancy.

- Each contract between a health maintenance organization and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence. Subject to Subsections (d) and (e), the health maintenance organization must provide continued reimbursement at not less than the contract rate in exchange for the enrollee's continued receipt of ongoing treatment from the physician or provider.
- The treating physician or provider shall identify a special circumstance. The treating physician or provider must:
    - request that an enrollee be permitted to continue treatment under the physician's or provider's care; and
    - agree not to seek payment from the enrollee of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the health maintenance organization delivery network.
- Except as provided by Subsection
- This section does not extend the obligation of a health maintenance organization to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:
    - the 90th day after the effective date of the termination; or
    - if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine- month period after the effective date of the termination.
- If an enrollee is past the 24th week of pregnancy at the time of termination, a health maintenance organization's obligation to reimburse a terminated physician or provider or, if applicable, an enrollee extends through delivery of the child and applies to immediate postpartum care and a follow-up checkup within the six-week period after delivery.
- A contract between a health maintenance organization and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

ACHP will work with you to facilitate the transition to a new provider as appropriate. Contact Customer Service toll-free at 1-844-800-4693 for more information.

Providers are required by contract to provide ACHP with a 90-day written notice of their intent to terminate their participation in the network. ACHP will make every effort to

provide a 30-day notice to impacted members when a provider's network relationship terminates. ACHP will work with you to facilitate the transition to a new provider as appropriate.

How To File Or Voice A Complaint

You have the right to file a complaint if you are unhappy about the services/ benefits or care you received from ACHP or a ACHP provider, call us at 1-844-800-4693. A full investigation will be conducted on your complaint. ACHP will let you know the results of our investigation and will follow-up with you in writing within 30 calendar days from receipt of your verbal or written complaint and/or Complaint Form.

You can also file a complaint by completing and returning the Complaint Form found on our website at www.accesstocarehealth.com

ACHP will not discriminate or take punitive action against a member or a member's representative for making a complaint, an Appeal, or requesting an Expedited Appeal. ACHP will not engage in retaliatory action including refusal to renew or cancel coverage because the member or a person acting on behalf of the member has filed a complaint against ACHP or appealed a decision of ACHP. Furthermore, ACHP is prohibited from retaliating against a physician or providers because the physician or provider has filed a complaint or appealed a decision on behalf of the enrollee.

At any time, you may file a complaint with the Texas Department of Insurance (TDI) by writing or calling:

Texas Department of Insurance (TDI)
Consumer Protection, MC: CO-CP
P.O. Box 12030
Austin, TX 78711-2030
Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

Appeal Process

You may appeal a decision that adversely affects your coverage, benefits or your relationship with ACHP. If you are not happy with the decision, you may file an appeal by phone or mail. You may call us toll-free at 1-844-800-4693 if you need assistance with starting the appeal process. If you need language, assistance let us know and we will provide translation services. You may send a written appeal to:

ACHP
Attn: Appeals
2028 East Ben White Blvd., Suite 400

Austin, TX 78741

If your circumstance involves a life-threatening condition, prescription drugs or intravenous infusions for which the patient is receiving health benefits under the evidence of coverage you are entitled to an immediate appeal to an Independent Federal External Review.

The Utilization Review shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the evidence of coverage no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

When you appeal an adverse determination for a concurrent review of health care services ACHP will provide:

- Coverage or benefits for the contested health care services, including prescription drugs and intravenous infusion, under the enrollee's evidence of coverage while the appeal is being considered; and
- Without regard to whether the adverse determination is upheld on appeal, ACHP can still charge an enrollee for the applicable copayment, under the enrollee's evidence of coverage, including prescription drugs and intravenous infusion, received during the period the appeal was considered except for an applicable copayment, under the enrollee's evidence of coverage.
- Furthermore, ACHP is prohibited from retaliating against a physician or providers because the physician or provider has filed a complaint or appealed a decision on behalf of the enrollee.

Expedited Appeals

An Expedited Appeal is when ACHP is required to make a decision quickly based on your health status, and taking the time for a standard appeal could jeopardize your life or health, such as when you are in the hospital continued treatment has been denied, prescription drugs or intravenous infusions. To request an Expedited Appeal, call our Meical Management department toll-free at 1-844-800-4693. You may also request an Expedited Appeal in writing. We will make a determination as soon as possible, taking into account the medical situation, but no later than 1 (one) working day from the date all information necessary to complete the appeal is received or 72 hours after ACHP receives the request, whichever is more stringent. We may provide the determination by telephone or electronic transmission but will provide a written determination within 3 calendar days of the initial telephonic or electronic notification.

Through the Expedited Appeals process, you have the right to continue any service you are presently receiving until the final decision of your appeal is issued. If the services being appealed are not medically necessary, you may be responsible for them. If ACHP denies your request for an expedited appeal, we will notify you. Your request will be moved to the regular appeals process. We will mail you our decision within 30 days.

Independent Federal External Review

Some appeals that are denied by ACHP may be reviewable by an Independent Federal External Review. Any member whose Appeal of an Adverse Determination is denied by ACHP may seek review of that determination by submitting an appeal request through the Federal External Review Process. To find out about the process to request a Federal External Review, you may call ACHP's Medical Management Department at 1-844-800-4693 for more information. You may also visit https://www.externalappeal.com to download and complete an HHS Federal External Review Request Form and return it to:

MAXIMUS Federal Services, Inc.,
3750 Monroe Avenue, Suite 705,
Pittsford, NY 14534,
Toll- Free phone: 1-888-866-6205
Fax: 1-888-866-6190

If you have any additional questions regarding this process, please call ACHP Medical Management Department at 1-844-800-4693, Monday – Friday 8 AM to 5 PM.

How To Obtain Information About Providers

Our Provider Directory contains information about the professional qualifications of our physicians. The Provider Online Search Tool at www.accesstocarehealth.com can supply information about our physicians' certification and indicate whether a particular provider is accepting new patients. It is a good idea to call the provider to make sure that they are in ACHP's network prior to receiving services. Customer Service can also give you more information about a provider's qualifications such as medical school attended, residencies, board certification status, and can let you know if a provider is accepting new patients. You can call Customer Service toll-free at 1-844-800-4693, if you would like more information about physicians and / or to request a printed copy of the provider directory.

Choosing Your Physician

Now that you have chosen ACHP, your next choice will be deciding who will provide most of your health care services. Your Primary Care Physician or Primary Care Provider (PCP) will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations.

Selecting A Primary Care Provider (PCP)

After you make your first initial payment, you must select a Primary Care Physician (PCP) for yourself as well as anyone else listed on your plan. You have a choice to select a provider who will provide most of your health care services. You will select a PCP from the ACHP network of family or general providers, internists and pediatricians, within your health benefits plan network.

The selection of a PCP is crucial for immediate access to acute and preventive care. Your PCP will provide and/or coordinate all aspects of your medical care and oversee your course of treatment to ensure that proper care is maintained. For a list of ACHP, providers visit our website at www.accesstocarehealth.com.

In-network providers, within your health benefits plan network, are in the Travis Service Area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties.

You can also call Customer Service toll-free at 1-844-800-4693 for assistance with finding a provider. ACHP uses standardized processes to evaluate and approve providers for our network. The practices of in-network providers are reviewed on a regular basis to ensure they continue to meet ACHP's standards.

Please assist your PCP by:

- Requesting that your prior medical records be transferred to your new PCP's office.
- Presenting your ACHP ID card every time you receive medical services.
- Paying the provider copayment(s) amounts at the time of service.
- Contacting your PCP as soon as possible after a medical emergency so he or she can arrange for follow up care.
- Obtaining a referral from your PCP before seeking non-emergency specialty medical care, except when accessing care from an obstetrician/gynecologist (OB/GYN) within your health benefits plan network or behavioral health provider

Your PCP is available, directly or through arrangements for coverage with other providers, 24 hours a day, 7 days a week. If you are admitted to an inpatient facility, a provider other than your PCP may direct and oversee your care. If you have a chronic, disabling or life-threatening condition, you may request to use a specialty care provider as your PCP. For a specialty care provider to be named as your PCP, he or she must meet all ACHP PCP requirements, and be willing to accept the responsibility of coordinating all of your health care needs. If you want to request a specialty care provider as your PCP, call Customer Service to make the change request.

ACHP provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: https://www.tdi.texas.gov/consumer/health-complaints.html.

If ACHP approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, ACHP must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment amounts.

You may obtain a current directory of network physicians and providers at the following website: at www.accesstocarehealth.com or by calling 1-844-800-4693 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of- network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to ACHP, dated not more than 30 days before you received the service.

Changing Your Primary Care Provider

We want our members to be satisfied with all aspects of their health care. If for any reason, you want to change your PCP call Customer Service toll-free at 1-844-800-4693. You may also request a PCP change through your secure member portal.

Selecting Your Obstetrician And Gynecologist

ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP that is within your health benefits plan network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP.

You have the right to obtain the following services with an in-network provider within your health benefits plan network, without a referral or an authorization from ACHP:

- One "well-woman" examination per year. This would include a pelvic, breast exam, and a Papanicolaou test (Pap test).
- Care for all gynecological conditions.

- Care for any disease or treatment within the scope of the provider's license, including diseases of the breast.

Check our website for a listing of in-network ACHP OB/GYN providers within your health benefits plan network: www.accesstocarehealth.com or contact Customer Service if you need additional information about how to access OB/GYN services.

Accessing Specialty Services

ACHP covers a full range of specialty services. If your PCP determines that your condition requires treatment by a specialist, he or she will refer you to the appropriate in-network specialist, within your health benefits plan network.

NOTE: You are not required to obtain a referral from your PCP to access care from an OB/GYN or behavioral health provider within your health benefits plan network.

For a list of specialty care providers in the ACHP network within your health benefits plan network, visit our website www.accesstocarehealth.com. ACHP providers will be in the Travis Service Area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties. The online search tool is updated every two weeks. You may also call Customer Service for the most current network provider information toll-free at 1-844-800-4693.

Service Area

ACHP products provide benefits to eligible members who reside, live or work in Travis County. ACHP has in-network providers and facilities within the Travis Service Area, which includes Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, and Williamson Counties, to provide you the health care treatment you need.

Scheduling Appointments

When scheduling an appointment to see a health care provider be specific about your medical needs. This information enables the provider's staff to schedule your appointment time appropriately. You should notify the provider's office as soon as possible if you cannot keep an appointment. Providers can charge you a fee if you do not cancel your appointment within 24-hours of the scheduled appointment time; this fee would be your responsibility. Ask your provider if he/she has a cancellation policy to ensure that you are not charged extra fees due to not canceling your appointment on time.

Coordination of Benefits

Coordination of Benefits (COB) is when a plan is allowed to determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan.

You are enrolled in an Off Exchange plan with ACHP, you must notify ACHP by calling 1-844-800-4693 if you gain or have access to other coverage such as a plan offered by an employer.

If you have any questions about coordination of benefits, contact Customer Service toll-free at 1-844-800-4693.

How To Submit A Claim For Covered Services

Most providers will file claims for you. A claim is a detailed invoice that your health care provider (such as your doctor, clinic, or hospital) sends to the health insurer. This invoice shows exactly what services you received. If the provider does not file a claim for services you received, you can submit the information yourself by using the claim form found online at www.accesstocarehealth.com

It is your responsibility to provide your plan coverage information at the time of service or as soon as possible, so your provider can submit claims timely. It is also important to respond to any correspondence sent to you by the provider.

You *may* be responsible for billed charges if your claim is not submitted to ACHP within 95 days from the date of service.

ACHP will pay completed claims based on our contracted rate received by in-network providers or facilities within the health benefits plan network.

If you receive emergency services from an out-of-network physician or provider, ACHP will fully reimburse the provider at the usual and customary rate or at an agreed rate.

ACHP will work to hold you harmless for any amounts beyond the copayment or other out-of-pocket amounts that you would have paid had ACHP's network included network physicians or providers from whom you could obtain emergency services in a non-network facility.

You will be held harmless for any amounts beyond the copayment or other out-of-pocket amounts in circumstances when non-emergency care is not available through a network physician or provider or on request of a network physician or provider, prior authorization is required and must be approved. Otherwise, non-emergency services received from an out-of-network provider or facility will not be covered.

Send your claim to:

ACHP
Attn: Claims
P. O. Box 17307
Austin, TX 78760

If you choose to receive non-emergency medical treatment from an out-of-network provider, at an out-of-network facility, in an emergency room, urgent care centers, or other facilities without authorization from ACHP, you will be responsible for the bill(s).

If you receive Emergency Services and you are balance billed, please contact Member Services at 1-844-800-4693. You should not be balance billed for Emergency Services. You may be required to submit a copy of the itemized billing statement for investigation purposes.

To help assist the provider with submitting claims timely to ACHP, please provide your plan coverage information as soon as possible and respond to any correspondence sent to you by the provider. You may be responsible for billed charges if your claim is not submitted to ACHP within 95 days from the date of service.

If you receive a bill for laboratory work or another service, which should have been sent to ACHP, contact Customer Service and we will assist you. Customer Service can also assist you if you paid for services which you believe should be reimbursed.

Medical Necessity

Your provider will make decisions about your care based on “medical necessity” for both medical and behavioral health services. Medically necessary means health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Medical necessity is:

- Reasonable and necessary to prevent illness or medical conditions or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s medical conditions;
- Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or government agencies;
- Consistent with the diagnosis of the conditions; and
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency;
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- Provided at the most appropriate level or supply of services which can safely be provided; and
- Care or services that could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care required.

Advance Directives

It is your right to accept or refuse medical care. Advance directives can protect you if you ever become mentally or physically unable to choose or communicate about your care due to injury or illness.

Utilization Management (UM) Decision Making Standards

UM decisions made by ACHP employees, delegates and contractors must be based solely on appropriateness of care and service and existence of coverage. ACHP does not specifically reward providers or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Denials Or Limitations Of Provider's Request For Covered Services

ACHP may deny coverage for health care services that are not covered by your benefit plan. If ACHP denies healthcare services, a letter will be mailed to you with the explanation for the denial including instructions on how to file an appeal, if applicable.

If you are not happy with the decision, you may file an appeal by phone or by mail. You may also request an appeal if ACHP denied payment of services in whole or in part for covered benefits from an in-network provider, within your health benefits plan network. You can mail your completed appeal form to us or call us toll-free at 1-844-800-4693. You can also download an appeal form at: www.accesstocarehealth.com. If you appeal by phone you or your representative will need to send us a written signed appeal. You do not need to do this if an Expedited Appeal is requested

Mail in appeal form to:

ACHP
Attn: Appeals
P. O. Box 17307
Austin, TX 78760

A letter will be mailed to you within five business days informing you that your appeal has been received. We will mail you our decision within 30 calendar days. If ACHP needs more information to process your appeal, we will notify you of what is needed within the appeal acknowledgement letter. For life threatening care concerns or hospital admissions, you may request an Expedited Appeal.

Customer Service

The ACHP Customer Service Department has specially trained representatives who are available to assist you with questions regarding your benefits.

They can:

- Assist you in choosing a PCP.
- Explain covered benefits and services.
- Help coordinate around any barriers to accessing health care.
- Send you a new ID card, EOB or any other lost member material.

Our Customer Service Representatives are available Monday through Friday 8:00 am to 5:00 pm toll-free at 1-844-800-4693. If you are hearing impaired, call TTY toll-free at 7-1-1 for assistance.

Language Assistance

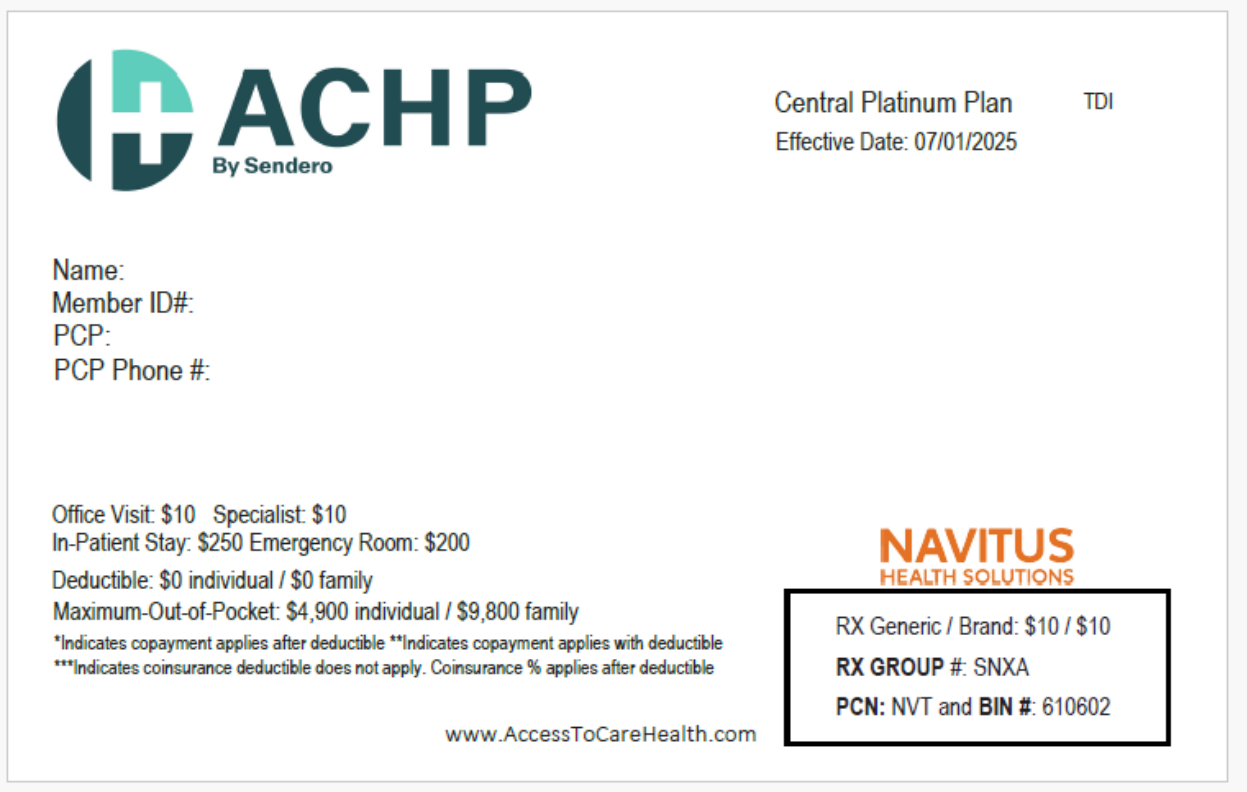
If you need to speak to a Customer Service Representative regarding your benefits, access to care, or have any other questions or concerns, please call us. We have bilingual representatives that can assist you in English and Spanish. If you speak a language other than English or Spanish, we can provide an interpreter over the phone to assist with translation. There is no charge for this service.

If you need face-to-face interpretation assistance for a medical appointment, call us toll-free at 1-844-800-4693. At minimum, we will need a 48-hour notice prior to your appointment date to schedule a face-to-face interpreter for your appointment.

Identification Card

ACHP Plan Members will receive a Member ID card which must be presented each time you visit a provider or obtain services. The ID card lists the Member name, Member ID number, Effective Date, Co-payment amounts and your selected PCP. Important telephone numbers are also listed on your ID card.

If you lose your ID card, call Customer Service toll-free at 1-844-800-4693 for a replacement card as soon as possible. ACHP does not allow anyone, other than the Member(s) listed on the ID card, to receive ACHP benefits. Keep your ID card to yourself. ACHP can terminate your coverage for fraudulent or intentional misrepresentation.



Confidentiality

We are committed to ensuring that your personal health information is secure and confidential. Our providers are held to the same standard. Except as required in administering your individual health care needs and fulfilling state and federal requirements, your personal information will not be disclosed without your written consent.

If you would like someone other than yourself to access your account, or if you are the Head of Household (HOH) or Legal Guardian of a minor covered by ACHP, you must submit a Protected Health Information (PHI) Form in order to obtain account information. The PHI form can be downloaded from the ACHP website. You can also contact Member Services at 1-844-800-4693 to request that a form be mailed to the address listed in the Member's account.

Notifications of Changes

If you are enrolled in an off-exchange plan directly with ACHP, it is your responsibility to notify ACHP within 30 days, or as soon as possible, of a qualifying event, such as a change in marital status, the addition of dependents, a court-ordered change in coverage or other changes that may affect eligibility. ACHP is responsible for all eligibility decisions. You will also need to contact ACHP directly to update your contact information or to terminate your coverage.

Grace Period

Grace Period is a time period in which an overdue premium can be paid after the due date and the member is able retain ongoing coverage.

Off Exchange Members have a one-month grace period starts the first day of the month that you fail to make a payment. For Example:

- You don't make your June payment by June 1st.
- You are now considered in Grace Period.
- Your Grace Period ends June 30th.
- If you do not pay your entire premium amount due, no later than June 30th, you will lose coverage.
- Your last day of coverage will be May 31st.

Premium Refunds

Members may call in to request a refund of overpaid premiums. The refunds can be processed by two methods, electronically or by a manual check. The type of refund that is issued depends on the method of payment. Payments made with a debit/credit card on our member portal/website, IVR, auto pay, may be reversed to your debit/credit card. Payments made by check/money order to our lockbox or auto pay with a checking or savings account are refunded by Electronic Funds Transfer (EFT) or manually via a live check. Please contact Customer Service at 1-844-800-4693 to request your refund.

Fraud, Waste & Abuse

If you suspect a person who receives benefits or a provider (e.g., provider, dentist, counselor, etc.) has committed waste, abuse or fraud, you have the responsibility and a right to report it.

Reporting Provider / Client Fraud, Waste And Abuse

To report Fraud, Waste or Abuse gather as much information as possible. You must report members or providers directly to: Lighthouse Services, and you must include ACHP's name in your report by using the:

- Confidential hotline at 833-290-0001
- Confidential fax at 215-689-3885
- Confidential email at reports@lighthouse-services.com
- Confidential website at www.lighthouse-services.com/senderohealth
- Call Customer Service at 1-844-800-4693; or
- You can report directly to:

ACHP, 2028 E. Ben White Blvd., Suite 400, Austin, TX 78741

When reporting a provider (e.g., dentist, counselor, etc.) provide the following:

- Name, address and phone number of provider;
- Name and addresses of the facility (hospital, nursing home, home health agency, etc.);
- Type of provider (provider, physical therapist, pharmacist, etc.);
- Names and the number of other witnesses who can aid in the investigation;
- Dates of events; and
- Summary of what happened

When reporting a person who receives benefits provide the following:

- The person's name;
- The person's date of birth or social security number (if available);
- The city where the person resides; and
- Specific details about the waste, abuse and/or fraud.
- Dates of events

Internal Protection Of Personal Health Information

The steps ACHP has taken to safeguard members' medical information include but are not limited to:

- Disseminated a Notice of Privacy Practices to covered members and posted it on the ACHP website at www.accesstocarehealth.com.
- Disseminated a Notice of Privacy Practices and other information to providers and facilities about ACHP's privacy practices.
- In daily interaction with members and providers, ACHP providers and Customer Service representatives inform providers and members of our procedures to verify identity and authority of callers to discuss protected health information.

Technology Assessment

ACHP systematically evaluates the inclusion of new technologies and the new applications of existing technologies as covered services in a timely manner. Your plan coverage benefit provides coverage only for therapies that have been shown in the scientific medical literature to be safe and effective. The ACHP technology assessment process assures that coverage will be available when evidence of safety and effectiveness exists. A review of current technology as well as care-specific reviews will be conducted by the ACHP medical technology assessment team using up-to-date information from sources including but not limited to evidence based medical literature, board certified consultants, physician work groups, professional societies, and government agencies. Drugs that are new to the medical community are reviewed and discussed by the ACHP pharmacy and therapeutics committee.

Subrogation

If the plan pays or provides medical benefits for an illness or injury that was caused by an act or omission of any party or entity, the plan will subrogate all rights of recovery of a ACHP member. The extent of subrogation will be to the level of benefits provided, the reasonable value of services, or benefits provided by the plan.

In addition, the ACHP member having accepted benefits by the plan, agrees to assign their claim against the person or entity responsible for their illness or injury to the plan to the extent of the benefits provided. ACHP member agrees to cooperate in any way with the plan or the plan's contractor in furtherance of the subrogation/assignment claim; agree to sign any authorization requested by the plan or its contractor; and authorizes the use of their medical records and billing records in furtherance of their subrogation/assignment claim.

Please see the EOC located at www.accesstocarehealth.com for a full description of your rights and obligations.

Members Rights And Responsibilities

As a ACHP member, you have certain rights and responsibilities, as outlined below.

You have the right to:

- Receive coverage for the medical benefits and treatment that is available when you need it and is handled in a way that respects your privacy and dignity.

- Receive information about your health benefit plan, services, and providers, member rights and responsibilities, including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Have a discussion and participate with your health care professional in health decisions and have your health care professional give you information about your medical condition and your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language you understand.
- Learn about any care you receive. You should be advised of who is available to assist you with any special ACHP programs or services you receive and who can assist you with any requests to change programs or services.
- Voice complaints and appeals about ACHP or any provider. Our process is designed to hear and act on your complaint or concern about ACHP and/or the quality of care you receive from health care professionals and the various places you receive care in our network;
- Provide a courteous, prompt response and guide you through our grievance process if you do not agree with our decision.
- Make recommendations regarding our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call Customer Service at the toll-free number on your ID card.

You have the responsibility to:

- Review and understand the information you receive about your health benefit plan. Please call Customer Service when you have questions or concerns.
- Understand how to obtain services and what supplies are covered under your plan.
- Show your ID card before you receive care.
- Understand your health condition and work with your provider to develop treatment goals that you both agree upon.
- Follow the plans and instructions for care that have been agreed upon by you and your provider.
- Supply information to ACHP and its providers in order to provide care to you.
- Pay all copay amounts for which you are responsible at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional’s office ahead of time if you are going to be late or miss an appointment.
- Voice your opinions, concerns or complaints to ACHP Customer Service and/or your health care professional.
- Notify your plan administrator and treating health care professional as soon as possible about any changes in family size, address, phone number or status with your health benefit plan if you decide to dis-enroll from ACHP’s programs and services.

Nondiscrimination And Accessibility

Access to Care Health Plan by Sendero (ACHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ACHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ACHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact ACHP.

If you believe that ACHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Access to Care Health Plan
Attn: Sharon Alvis
2028 E. Ben White Blvd., Suite 400
Austin, TX 78741
Telephone: 1-8844-800-4693
TTY: 711
Complaints@Senderohealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a complaint, ACHP Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TTY)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html