Member Appeal to an Adverse Determination (Marketplace)

You received a Notice of Adverse Determination. This means that Community has:

- Denied or reduced the authorization of a service.

The enrollee or someone acting on the enrollee's behalf and the provider of record have the right to appeal this adverse determination (denial) orally or in writing. A physician who has not previously reviewed the case will make the appeal decision. The appealing party must send us the appeal no later than 180 days after the date of the letter.

There are Four types of Appeals:

Standard Appeal: An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization. The appeal is resolved in 30 calendar days from receipt of the appeal. You, your provider or someone else that you choose as your representative have the right to appeal an Adverse Determination. You may request your appeal verbally or in writing. Please send your appeal to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, Texas 77054
713-295-6704 or 1-855-315-5386 or TTY 711
Fax to: 713-295-7033/Attn: Appeals Coordinator

We will let you know we received your appeal within 5 business days. Community may need additional information to help us with your appeal. The letter will include a list of documents that you, your representative or Provider should send to Community for the appeal. You have the right to give us information which supports your appeal. You may review any information we use to make our decision.

Community will have someone review the appeal to make sure we have all the required information. A physician who has not previously reviewed the case will make the appeal decision.

- **Expedited Appeal:** An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized enrollees. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits. The appeal is resolved in one working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission, but will provide a written determination within three working days of the initial telephonic or electronic notification

- **Specialty Appeal:** If we deny the appeal, the provider of record may request a specialty appeal, which requests that a specific type of specialty review the case. The provider must request this type of appeal in writing within 10 working days from the denial and must show good cause for the specialty appeal. We will complete the specialty appeal and send our written decision to the enrollee or the person acting on the enrollee's behalf and the provider within 15 working days of receipt of the request for the specialty appeal.

- **Retrospective (Claim) Appeal:** Adverse determinations related to retrospective reviews will be made within a reasonable period but not to exceed 30 calendar days after the claim is received. The determination will be sent to the Provider, enrollee or a person acting on behalf of the enrollee in writing.

- **Acquired Brain Injury Appeal:** An appeal of denied services concerning an acquired brain injury. The appeal is resolved no later than three business days after the date on which the individual submits the appeal. The notification of the determination must be provided through a direct telephone contact to the individual making the request. We will provide a written determination within 30 calendar days of receipt of the appeal.

- Appeal Acknowledgment: Within five (5) working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal from but we encourage its return because the form will help us resolve the appeal.

- Life-Threatening Conditions: If the patient has a life-threatening condition or receives a denial for prescription drugs or intravenous infusions for which they are currently receiving benefits, the patient, or someone acting on the patient's behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the independent review.

- Exhaustion of Internal Appeals: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation files an external review before exhausting our internal appeal process, or (c) we decide to waive the appeal process requirements.

Independent Review Organization

If we deny the appeal (continue to deny the services or treatment described above), the Enrollee or someone acting on the enrollee's behalf and the provider of record have the right to request a review by an Independent Review Organization (IRO). The IRO does not have an affiliation with your health plan or health care providers. You can request an IRO review at any time; however, try to request the review as soon as possible. An IRO works with the Texas Department of Insurance. An IRO makes decisions on medical necessity and whether your care is appropriate.

You have the right to a review of an appeal by an Independent Review Organization (IRO) for urgent or life threatening conditions.

To request the independent review, fill out the enclosed TDI form (LHL009) and return it to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Ste. 125
Houston, Texas 77054
713-295-6704 or toll-free at 1-855-315-5386 or TTY 711
Fax to: 713-295-7033/Attn: Appeals Coordinator

The enrollee, parent, or the enrollee's legal guardian must sign the consent to release medical information to the IRO (included as part of the IRO form).

Complaint Procedures

Enrollees, individuals acting on behalf of enrollees, and health care providers may file a written or oral complaint about our utilization review process and procedures. We will send you a letter within 5 (five) business days letting you know that we have received your complaint. Once we receive your complaint, we will investigate it and respond with a written letter within 30 calendar days.

To file an oral complaint, please call 713.295.6704 or toll free at 1.855.315.5386 or TTY 711.

Please send written complaints to:

Community Health Choice, Inc.
Attention: Service Improvement
2636 South Loop West, Ste. 125
Houston, Texas 77054
713-295-6704 or toll-free at 1-855-315-5386 or TTY 711
Fax to: 713-295-7034/Attn: Service Improvement

Complaints to TDI: A complainant also has the right to file a complaint with TDI by contacting TDI at the following address, telephone numbers, or website:

Texas Department of Insurance
PO Box 149091
Austin, TX 78714-9091
1-800-252-3439
Fax: 512-490-1007
Online: www.tdi.texas.gov

If you have any questions or need help, please call our Member Services Department.
713-295-6704 • 1-855-315-5386

Attachment: Request for Review by an IRO (TDI Form LHL009), Enrollee Appeal Form,

TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ★ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)
INSTRUCTIONS

(DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE)

Instructions to Patient, Person Acting on Behalf or Representative of Patient/Employee, and Provider:
This form is being provided to you because your request for health care services has been denied as not medically necessary by your insurance carrier. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier (company). This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

To request an independent review of your case, you must take the following action:

- Complete the Request for a Review by an Independent Review Organization form (TDI Form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- RETURN THE COMPLETED FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES AS SOON AS POSSIBLE. (For Workers' Compensation cases, you must return this form within 45 calendar days).
    - Carrier instructions: Complete the "Company or URA That Denied Services" Section on page 4.
    - Note to patients: The company address and/or fax number can be found on the denial letter.

The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned. The timeframes for an IRO's decision are as follows:

Coverage Types	Health	Workers' Compensation Network (WCN)	Workers' Compensation Non-Network (WC)
Life Threatening	3 days	8 days	8 days
Denial of Prescription Drugs or Intravenous Infusions - Concurrent	3 days	NA	NA
Denial of an exception request to a prescription drug step therapy protocol - Preauthorization	3 days	NA	NA
Non-Life Threatening Preauthorization/Concurrent	20 days	20 days	20 days
Retrospective	20 days	30 days from receipt of IRO fee*	30 days from receipt of IRO fee**

*Carrier pays the fee.
**Requestor pays the fee. (However, if the requestor is an injured employee, carrier pays the fee.)

There is no cost to you for the independent review. **Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginning its review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.**

REQUEST FORM

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month_____ Day_____ Year_____

Name of Party Requesting Independent Review: _____ **Print Last Name, First Name and Middle Initial**	**Relationship to the Patient or Injured Employee:** **(Check one)** ☐ Self (complete page 3, item A) ☐ Person acting on behalf of patient or injured employee (complete page 3, items A and C) ☐ Provider acting on behalf of patient or injured employee (complete page 3, items A and B) ☐ Provider that received the denial (complete page 3, item A) ☐ Sub claimant (Workers' Compensation only) (complete page 3, items A and C)

REASON FOR REQUEST FOR REVIEW BY AN IRO

APPLIES TO HEALTH AND WORKERS COMPENSATION CASES:	APPLIES TO HEALTH CASES ONLY:
Is the condition life-threatening? Check one: ☐ Yes ☐ No (This question does not apply if services have been received) Is the review ordered by a Court? Check one: ☐ Yes ☐ No	Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits? Check one: ☐ Yes ☐ No Is this a denial of an exception request to a prescription drug step therapy protocol: Check one: ☐ Yes ☐ No

DENIED SERVICES

Describe the health care services that are being denied (include dates only if services have been performed):

_____

_____

PATIENT/INJURED EMPLOYEE INFORMATION

Health Plan or Claim Identification Number:_____

(This number is usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of Birth:*(month)*_____ *(day)*_____ *(year)*_____ Sex_____

First Name_____Middle Name _____ Last Name _____Suffix_____

Street _____

City_____ State_____ Zip code_____

Phone _____-_____ Fax _____-_____

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES.
(DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

A. PROVIDER THAT RECEIVED THE DENIAL

Name_____

Federal Tax Identification Number _____

Street_____

City_____ State_____ Zip code_____

Phone _____-_____ Fax _____-_____

B. PROVIDER ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF IF APPLICABLE

Name_____

Federal Tax Identification Number _____

Street_____

City_____State_____ Zip _____

Phone number: _____-_____Fax number: _____-_____

C. PERSON ACTING ON PATIENT'S/INJURED EMPLOYEE'S BEHALF IF APPLICABLE

First Name_____Middle Name _____Last Name _____Suffix_____

Relation to patient _____

Street_____

City_____State_____Zip _____

Phone number _____-_____Fax number _____-_____

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES. (DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

RELEASE

(The release must be signed by the patient, or his or her parent or legal guardian.)
(NOT REQUIRED FOR WORKERS' COMPENSATION CASES)

I,_____ **(Print last name, first name and middle initial)**, the patient, parent, or patient's legal guardian *(circle one)*, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed_____ Date: *(mo)* _____ *(day)* _____*(yr.)* _____

Note: For chemical dependency or mental health treatment, list the providers to which this release applies:

_____

_____

_____

_____

COMPANY OR UTILIZATION REVIEW AGENT THAT DENIED SERVICES

(This section to be completed ONLY by the company or URA that denied services.)

Name of Company _____

Address _____

City _____ State _____ Zip _____

Toll-Free Number _____ Fax Number _____

The person requesting the independent review should submit this form to the company, as given, in this section. (Do not submit this form to TDI.)

NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled to be informed about the information the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.

FOR INFORMATION ABOUT THE INDEPENDENT REVIEW PROCESS, PLEASE CALL TDI AT 1-866-554-4926, OPTION 7.

RETURN THIS FORM TO THE COMPANY THAT IS DENYING YOUR REQUEST FOR HEALTH CARE SERVICES.
(DO NOT RETURN THIS FORM TO THE TEXAS DEPARTMENT OF INSURANCE.)

TEXAS DEPARTMENT OF INSURANCE
Financial Regulation Division - Managed Care Quality Assurance (103-6A)
333 Guadalupe, Austin, Texas 78701 ★ PO Box 149104, Austin, Texas 78714-9104
(512) 676-6400 | F: (512) 490-1013 | (866) 554-4926 | TDI.texas.gov | @TexasTDI

NO REGRESE ESTE FORMULARIO A TDI

SOLICITUD PARA UNA REVISIÓN POR PARTE DE UNA ORGANIZACIÓN DE REVISIÓN INDEPENDIENTE (INDEPENDENT REVIEW ORGANIZATION –IRO, por su nombre y siglas en inglés)

INSTRUCCIONES

Instrucciones para el Paciente, Persona que Actúe en Nombre del Paciente o Representante del Paciente/Empleado, y Proveedor:

Este formulario se le ha proporcionado a usted debido a que su solicitud para obtener servicios de cuidados de salud ha sido denegada ya que ha sido considerado que dichos servicios no son médicamente necesarios. Ahora usted puede solicitar que su caso sea revisado por parte de un proveedor de servicios médicos que sea totalmente independiente de su plan de salud o de su aseguradora. Esto es llamado una revisión independiente por parte de una Organización de Revisión Independiente o una "IRO". Usted, su proveedor de servicios médicos, o alguien que actúe en su nombre o su representante pueden presentar este formulario.

Para solicitar una revisión independiente en su caso, debe tomar las siguientes medidas:

- Completar la Solicitud para una Revisión por parte de una Organización de Revisión Independiente (Formulario de TDI LHL009).
- Firmar el formulario para que la IRO pueda recibir sus expedientes médicos. (La firma no es requerida para los casos de Compensación para Trabajadores).
- Regresar lo antes posible el formulario completo a la compañía que le envió la carta de rechazo (denial letter, por su nombre en inglés). La dirección de la compañía y/o el número de fax son mostrados ya sea en la página número cuatro de este formulario o en las cartas de rechazo. NO ENVÍE ESTE FORMULARIO AL DEPARTAMENTO DE SEGUROS DE TEXAS (Texas Department of Insurance -TDI, por su nombre y siglas en inglés). (Para los casos de Compensación para Trabajadores, usted debe regresar este formulario – para solicitar una IRO – dentro del lapso de tiempo de 45 días calendario).

La compañía enviará su solicitud para una revisión independiente a TDI. Una vez que TDI reciba el formulario de la compañía, TDI asignará su caso a una IRO. Usted recibirá una carta de parte de TDI donde se identificará la IRO a la que su caso ha sido asignado.

Los límites de tiempo para que una IRO emita una decisión son los siguientes:

Tipos de Cobertura	Salud	Red de Compensación para Trabajadores (Workers' Compensation Network –WCN, por su nombre y siglas en inglés)	Compensación para Trabajadores Fuera de la Red (Workers' Compensation Non-Network – WC, por su nombre y siglas en inglés)
Pone en Peligro la Vida	3 días	8 días	8 días
Denegación de Medicamentos con Receta o Infusiones Intravenosas – Concurrente	3 días	NA	NA

No Pone en Peligro la Vida Pre autorización/Concurrente	20 días	20 días	20 días
Retrospectiva	20 días	30 días a partir de la fecha en que se recibe el honorario de la IRO*	30 días a partir de la fecha en que se recibe el honorario de la IRO**

*La aseguradora paga el honorario.
**El solicitante paga el honorario (Sin embargo, si el solicitante es un empleado lesionado, la aseguradora paga el honorario.)

Instrucciones para el URA/Aseguradora:
APLICA SOLAMENTE EN CASOS DE SALUD: La entidad que está presentando esta solicitud ante TDI debe indicar en la documentación que se trata de una denegación de medicamentos con receta o infusiones intravenosas para el cual la persona inscrita ya está recibiendo beneficios.

No hay costo alguno para su revisión independiente. **Excepción solamente para la Compensación para Trabajadores Fuera de la Red: Un proveedor de servicios médicos que solicita una revisión retrospectiva independiente estará obligado a pagar los honorarios de la IRO antes que la IRO comience su revisión. Sin embargo, si la IRO falla a favor del proveedor de servicios médicos, el proveedor de servicios médicos será reembolsado por la aseguradora la cantidad de los honorarios de la IRO.**

Para obtener información sobre el proceso de revisión independiente, por favor llame a TDI al 1-866-554-4926, Opción 7.

ESTE FORMULARIO DEBE REGRESARSE A LA COMPAÑÍA QUE EMITIÓ LA NEGATIVA.

NO REGRESE ESTE FORMULARIO A TDI.

FORMULARIO DE SOLICITUD

SOLICITUD PARA UNA REVISIÓN POR PARTE DE UNA ORGANIZACIÓN DE REVISIÓN INDEPENDIENTE

Fecha del Día de Hoy: Mes_____ Día_____ Año_____

Nombre del Participante que solicita la IRO: _____ **Escriba en Letra de Molde su Apellido, Nombre, e Inicial**	**Relación con el Paciente o Empleado Lesionado:** **(Indique uno)** ☐ Sí mismo ☐ Persona que está actuando en nombre del paciente o del empleado lesionado ☐ Proveedor que está actuando en nombre del paciente o del empleado lesionado ☐ Proveedor que recibió la negativa ☐ Sub-reclamante (solamente Compensación para Trabajadores)

RAZÓN DE LA SOLICITUD PARA LA REVISIÓN POR PARTE DE UNA IRO

¿Pone en peligro la vida esta condición? Indique uno: ☐ Sí ☐ No (Esta pregunta no aplica si los servicios ya han sido recibidos)	¿Es esta una denegación de medicamentos con receta o infusiones intravenosas por la cual usted ya está recibiendo beneficios? ☐ Sí ☐ No (Esta pregunta no aplica en los casos de compensación para trabajadores)
¿Ha sido ordenada esta revisión por una corte? ☐ Sí ☐ No	

SERVICIOS DENEADOS

Describa los servicios de cuidados de salud que han sido denegados (incluya las fechas solamente si los servicios ya han realizados):

_____

INFORMACIÓN SOBRE EL PACIENTE/EMPLEADO LESIONADO

Número de Plan de Salud o Número de Identificación de la Reclamación:_____
(Este número por lo general se encuentra en la tarjeta de identificación del plan de salud del paciente. El número identifica al paciente con la aseguradora. Ingrese el número de reclamación de DWC para los casos de compensación para trabajadores.)

Fecha de nacimiento:*(mes)* _____ *(día)* _____ *(año)*_____ Sexo_____

Número de Seguro Social _____-_____-_____

Nombre_____ Segundo Nombre _____ Apellido _____Nombre Sufijo_____

Calle _____

Ciudad_____ Estado_____ Código Postal_____

Teléfono: _____-_____ Fax: _____-_____

PROVEEDOR QUE RECIBIÓ LA NEGATIVA

Nombre_____

Número de Identificación de Impuestos Federales (Federal Tax Identification Number, por su nombre en inglés)

_____

Calle_____

Ciudad_____ Estado_____ Código Postal_____

Teléfono: _____-_____ Fax: _____-_____

PROVEEDOR QUE ESTÁ ACTUANDO EN NOMBRE DEL PACIENTE/EMPLEADO LESIONADO *(SI ES QUE APLICA)*

Nombre_____

Número de Identificación de Impuestos Federales (Federal Tax Identification Number, por su nombre en inglés)

_____

Calle_____

Ciudad_____ Estado_____ Código Postal_____

Número de Teléfono: _____-_____ Número de Fax: _____-_____

PERSONA QUE ESTÁ ACTUANDO EN NOMBRE DEL PACIENTE/ EMPLEADO LESIONADO *(SI ES QUE APLICA)*

Nombre _____ Segundo Nombre_____ Apellido _____ Nombre Sufijo_____

Relación con el Paciente _____

Calle _____

Ciudad _____ Estado _____ Código Postal _____

Número de Teléfono: _____-_____ Número de Fax: _____-_____

ACUERDO PARA LA ENTREGA DE INFORMACIÓN (El acuerdo debe ser firmado por el paciente, o por su tutor legal.)
(ESTO NO ES REQUERIDO PARA LOS CASOS DE COMPENSACIÓN PARA TRABAJADORES)

Yo,_____ **(Escriba en letra de molde el apellido, nombre e inicial)**, el paciente, padre/ madre, o tutor legal del paciente ***(circule uno)***, autorizo que se le entreguen a la Organización de Revisión Independiente todos los expedientes médicos necesarios y otros documentos que sean relevantes para la revisión, que estén en poder del Agente para la Revisión de Utilización (Utilization Review Agent, por su nombre en inglés) o cualquier médico, hospital, u otro proveedor de servicios médicos.

Firmado_____ Fecha: *(mes)* _____ *(día)* _____*(año)* _____

Nota: Para el tratamiento por dependencia a sustancias químicas o salud mental, indique el nombre de los proveedores para los cuales aplica este acuerdo:

_____

_____

_____

_____

_____

REGRESE ESTE FORMULARIO A LA ASEGURADORA/PAGADOR O AGENTE PARA LA REVISIÓN DE UTILIZACIÓN

Nombre de la Compañía: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Número de Teléfono Gratuito: _____ Número de Fax: _____

Aviso sobre Cierta Información, Leyes y Prácticas
Con pocas excepciones, usted tiene derecho a ser informado sobre la información que el Departamento de Seguros de Texas (TDI, por sus siglas en ingles) reúne sobre usted. Bajo las Secciones 552.021 y 552.023 del Código Gubernamental de Texas, usted tiene derecho a revisar o recibir copias de la información sobre usted, incluyendo información que es privada. Sin embargo, es posible que TDI no de a conocer la información por razones diferentes a las de proteger su derecho a la privacidad.

Bajo la Sección 559.004 del Código Gubernamental de Texas, usted tiene derecho a solicitar que TDI corrija la información incorrecta que TDI tiene sobre usted. Para obtener más información sobre el procedimiento y los costos para obtener información de TDI o sobre el procedimiento para corregir información que mantiene TDI, por favor visite la sección para el Procedimiento de Correcciones en el sitio Web de TDI.

PARA OBTENER INFORMACIÓN SOBRE EL PROCESO DE REVISIÓN INDEPENDIENTE, POR FAVOR LLAME AL 1-866-554-4926, OPCIÓN 7.

Language Assistance

Community Health Choice, Inc. is required by federal law to provide the following information.

1. Arabic	يتضمن هذا الإشعار معلومات مهمة. وتتعلق هذه المعلومات الهامة في الإشعار بخصوص طلبك أو التغطية تحت التأمين الصحي Community Health Choice. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراءات قبل مواعيد محددة للحفاظ علي تأمينك الصحي أو مساعدتك في دفع التكاليف. لديك الحق في الحصول علي هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل علي 1.844.515.4877.
2. Chinese	本通知有重要信息。本通知包含關于您透過Community Health Choice提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前采取行動，以保留您的健康保險或費用補貼。您有權免費以您的母語得到本訊息和幫助。請撥電話 1.844.515.4877.
3. English	This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.844.515.4877
4. French	Cet avis contient d'importantes informations. Cet avis contient d'importantes informations concernant votre demande ou votre couverture avec Community Health Choice. Consultez les dates figurant dans le présent avis car il est possible que vous ayez à prendre certaines mesures avant ces dates pour conserver votre assurance santé ou profiter de meilleurs coûts. Vous êtes en droit de recevoir ces informations et de bénéficier gratuitement d'une aide dans votre langue. Appelez le 1.844.515.4877.
5. German	Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag auf Krankenversicherung bzw. Ihren Versicherungsschutz mit Community Health Choice. Achten Sie auf wichtige Termine in dieser Mitteilung. Eventuell müssen Sie zu bestimmten Stichtagen Maßnahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung zu gewährleisten. Sie haben ein Recht auf die kostenfreie Bereitstellung dieser Informationen und weiterer Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.844.515.4877.
6. Gujarati	આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અથવા કવરેજ વિશે મહત્વની જાણકારી છે. આ નોટિસમાં મહત્વની તારીખો માટે જુઓ. તમારા આરોગ્ય કવરેજને રાખવા અથવા ખર્ચ બાબતે મદદ કરવા માટે અમુક ચોક્કસ મુદત સુધી પગલાં લેવાની તમારે જરૂર પડી શકે છે. તમને કોઈ પણ ખર્ચ વિના તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.844.515.4877 પર કૉલ કરો.

7. Hindi	इस सूचनामें महत्वपूर्ण जानकारी है। इस सूचनामें आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूर्ण जानकारी है। इस सूचना में महत्वपूर्ण तारीखों केलिए खोजिये । आप अपने स्वास्थ्यके कवरेज रखने केलिए या लागत के मदद केलिए निश्चित समय सीमासे कार्रवाई करना जरूरत हो सकती है। आपको अपनी भाषा में इस जानकारी और सहायता निःशुल्क प्राप्त करने का अधिकार है। 1.844.515.4877 बुलाइये ।
8. Japanese	この通知には必要な情報が含まれています。この通知にはCommunity Health Choice の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1.844.515.4877 までお電話ください。
9. Korean	이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다.. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다. 1.844.515.4877로 연락하십시오.
10. Laotian	ຫນັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ຫນັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະຫມັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີ່ທີ່ສຳຄັນໃນຫນັງສືແຈ້ງການນີ້.ທ່ານອາດຈະຕ້ອງປະຕິບັດຜ່ານໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອໃນເຣື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ 1.844.515.4877.
11. Persian	این اطلاعیه حاوی اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضانامه و پوشش بیمه ای شما توسط Community Health Choice می باشد. به تاریخ های ذکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگهداشتن پوشش بیمه ای یا دریافت کمک هزینه، ممکن است نیاز باشد که تا مهلت های مقرر، اقداماتی را انجام دهید. حق شماست که این اطلاعات و کمک را بطور رایگان به زبان خودتان دریافت نمایید. با شماره تلفن 1.844.515.4877 تماس بگیرید.
12. Russian	Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Community Health Choice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.844.515.4877.

13. Spanish or Spanish Creole	Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.844.515.4877.
14. Tagalog	Ang Notisyang ito ay naglalaman ng Importanteng Impormasyon. Maayroon itong importanteng impormasyon tungkol sa inyong aplikasyon o pagpapaseguro sa pamamagitan Community Health Choice. Hanapin ang mga importanteng petsa sa notisyang ito. Maaaring may kailangan kayong gawin bago ang mga itinakdang deadline para manatiling nakaseguro o para matulungan kayo sa mga kailangang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalin sa inyong wika na wala kayong babayaran. Tawagan ang 1.844.515.4877.
15. Urdu	اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں Community Health Choice کے ذریعے آپ کی درخواست یا بیمے کے تحفظ سے متعلق اہم معلومات ہیں۔ اس نوٹس میں اہم تاریخوں کو دیکھیے۔ اپنی صحت کے بیمے کے تحفظ کو برقرار رکھنے یا اخراجات میں مدد کے لیے آپ کوکچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہے۔ آپ کوان معلومات اور مدد کواپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے۔1.844.515.4877 پر رابطہ کریں۔
16. Vietnamese	Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về mẫu đơn của bạn hoặc bảo hiểm qua chương trình Community Health Choice. Xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải thực hiện trong thời hạn nhất định để giữ bảo hiểm sức khỏe của bạn hay giúp đỡ chi phí. Bạn có quyền được thông tin này và giúp đỡ trong ngôn ngữ của bạn miễn phí. Xin gọi 1.844.515.4877.

Non-Discrimination Statement: Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Care Center at 1.844.515.4877. If you believe that Community Health Choice, Inc. 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.

If you need help filing a grievance, Nike Otuyelu, Vice President-Corporate Compliance & Risk Management, is available to help you. You can file a grievance in person or by mail, fax, or email:

Nike Otuyelu, Vice President-Corporate Compliance & Risk Management
2636 South Loop West, Suite 125
Houston, Texas 77054
Phone: 1.844.515.4877
Email: ERS_Grievances@communitycares.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at 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 (TDD)