



Community Health Choice  
Health Insurance Marketplace

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# PHARMACY BENEFIT





# YOUR PHARMACY BENEFIT

Welcome to Navitus Health Solutions, the pharmacy benefit manager for Community Health Choice. We're committed to lowering drug costs, improving health and delivering superior service. This booklet contains important information about your pharmacy benefit.

We look forward to serving you!

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# CUSTOMER CARE

## HOURS:

24 Hours a Day | 7 Days a Week

1-866-333-2757 (toll-free)  
TTY (toll-free) 711

## MAILING ADDRESS:

Navitus Health Solutions  
P.O. Box 999 | Appleton, WI 54912-0999

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## WEBSITE:

[www.navitus.com](http://www.navitus.com)

# PHARMACY BENEFIT SCHEDULE

Benefit Effective Date January 1, 2020				Benefit Type Health Insurance Marketplace		
Group	Retail In-Network Pharmacy 1-30 Days' Supply			Retail In-Network Pharmacy 90 Days' Supply		
	Tier 1 Generic and lower cost brand products	Tier 2 Preferred brand and higher cost generics	Tier 3 Non preferred brand (could include both brand and generic products)	Tier 1 Generic and lower cost brand products	Tier 2 Preferred brand and higher cost generics	Tier 3 Non preferred brand (could include both brand and generic products)
HMO Bronze 003 Off Exchange	\$15 All Tier 1 generics bypass deductible	\$70 After deductible	\$120 After deductible	\$45 All Tier 1 generics bypass deductible	\$210 After deductible	\$360 After deductible
HMO Bronze 003	\$15 All Tier 1 generics bypass deductible	\$70 After deductible	\$120 After deductible	\$45 All Tier 1 generics bypass deductible	\$210 After deductible	\$360 After deductible
HMO Bronze 003 Zero Cost Sharing Plan Variation	\$0	\$0	\$0	\$0	\$0	\$0
HMO Bronze 003 Limited Cost Sharing Plan Variation	\$15 All Tier 1 generics bypass deductible	\$70 After deductible	\$120 After deductible	\$45 All Tier 1 generics bypass deductible	\$210 After deductible	\$360 After deductible
	\$0 when filled through an Indian Health Service Provider					
HMO Silver 004 Off Exchange	\$10 All Tier 1 generics bypass deductible	\$60 After deductible	\$100 After deductible	\$30 All Tier 1 generics bypass deductible	\$180 After deductible	\$300 After deductible
HMO Silver 004	\$10 All Tier 1 generics bypass deductible	\$60 After deductible	\$100 After deductible	\$30 All Tier 1 generics bypass deductible	\$180 After deductible	\$300 After deductible

HMO Silver 004 Zero Cost Sharing Plan Variation	\$0	\$0	\$0	\$0	\$0	\$0
HMO Silver 004 Limited Cost Sharing Plan Variation	\$10 All Tier 1 generics bypass deductible	\$60 After deductible	\$100 After deductible	\$30 All Tier 1 generics bypass deductible	\$180 After deductible	\$300 After deductible
	\$0 when filled through an Indian Health Service Provider					
HMO Silver 004 94	\$5	\$20	\$40	\$15	\$60	\$120
HMO Silver 004 87	\$10	\$50	\$85	\$30	\$150	\$255
HMO Silver 004 73	\$10 All Tier 1 generics bypass deductible	\$50 After deductible	\$90 After deductible	\$30 All Tier 1 generics bypass deductible	\$150 After deductible	\$270 After deductible
HMO Gold 001 Off Exchange	\$20	\$40	\$80	\$60	\$120	\$240
HMO Gold 001	\$20	\$40	\$80	\$60	\$120	\$240
HMO Gold 001 Zero Cost Sharing Plan Variation	\$0	\$0	\$0	\$0	\$0	\$0
HMO Gold 001 Limited Cost Sharing Plan Variation	\$20	\$40	\$80	\$60	\$120	\$240
	\$0 when filled through an Indian Health Service Provider					
HMO Gold 005 Off Exchange	\$10 All Tier 1 generics bypass deductible	\$40 After deductible	\$70 After deductible	\$30 All Tier 1 generics bypass deductible	\$120 After deductible	\$210 After deductible
HMO Gold 005	\$10 All Tier 1 generics bypass deductible	\$40 After deductible	\$70 After deductible	\$30 All Tier 1 generics bypass deductible	\$120 After deductible	\$210 After deductible
HMO Gold 005 Zero Cost Sharing Plan Variation	\$0	\$0	\$0	\$0	\$0	\$0
HMO Gold 005 Limited Cost Sharing Plan Variation	\$10 All Tier 1 generics bypass deductible	\$40 After deductible	\$70 After deductible	\$30 All Tier 1 generics bypass deductible	\$120 After deductible	\$210 After deductible
	\$0 when filled through an Indian Health Service Provider					



HMO Bronze 008 High Deductible Health Plan Off Exchange	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
HMO Bronze 008 High Deductible Health Plan	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
HMO Bronze 008 Zero Cost Sharing Plan Variation	No charge	No charge	No charge	No charge	No charge	No charge
HMO Bronze 008 Limited Cost Sharing Plan Variation	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
HMO Silver 009 Off Exchange	\$15 All Tier 1 generics bypass deductible	\$70 After deductible	\$120 After deductible	\$45 All Tier 1 generics bypass deductible	\$210 After deductible	\$360 After deductible
HMO Silver 009	\$15 All Tier 1 generics bypass deductible	\$70 After deductible	\$120 After deductible	\$45 All Tier 1 generics bypass deductible	\$210 After deductible	\$360 After deductible
HMO Silver 009 Zero Cost Sharing Plan Variation	\$0	\$0	\$0	\$0	\$0	\$0
HMO Silver 009 Limited Cost Sharing Plan Variation	\$15 All Tier 1 generics bypass deductible	\$70 After deductible	\$120 After deductible	\$45 All Tier 1 generics bypass deductible	\$210 After deductible	\$360 After deductible
\$0 when filled through an Indian Health Service Provider						
HMO Silver 009 94	\$5	\$20	\$40	\$15	\$60	\$120
HMO Silver 009 87	\$10	\$50	\$85	\$30	\$150	\$255
HMO Silver 009 73	\$10 All Tier 1 generics bypass deductible	\$50 After deductible	\$100 After deductible	\$30 All Tier 1 generics bypass deductible	\$150 After deductible	\$300 After deductible

**The annual Out-of-Pocket (OOP) Maximum is based on combined prescription and medical expense and is calculated per calendar year. Member's copay/coinsurance amount is \$0.00 for remainder of calendar year after the OOP maximum amount is met for the calendar year.**

<b>Group</b>	<b>Individual OOP Amount</b>	<b>Family OOP Amount</b>
HMO Bronze 003 Off Exchange	\$8,150.00	\$16,300.00
HMO Bronze 003	\$8,150.00	\$16,300.00
HMO Bronze 003 Zero Cost Sharing Plan Variation	\$0.00	\$0.00
HMO Bronze 003 Limited Cost Sharing Plan Variation	\$8,150.00	\$16,300.00
HMO Silver 004 Off Exchange	\$7,900.00	\$15,800.00
HMO Silver 004	\$7,900.00	\$15,800.00
HMO Silver 004 Zero Cost Sharing Plan Variation	\$0.00	\$0.00
HMO Silver 004 Limited Cost Sharing Plan Variation	\$7,900.00	\$15,800.00
HMO Silver 004 94	\$2,500.00	\$5,000.00
HMO Silver 004 87	\$2,700.00	\$5,400.00
HMO Silver 004 73	\$6,500.00	\$13,000.00
HMO Gold 001 Off Exchange	\$8,150.00	\$16,300.00
HMO Gold 001	\$8,150.00	\$16,300.00
HMO Gold 001 Zero Cost Sharing Plan Variation	\$0.00	\$0.00
HMO Gold 001 Limited Cost Sharing Plan Variation	\$8,150.00	\$16,300.00
HMO Gold 005 Off Exchange	\$6,500.00	\$13,000.00
HMO Gold 005	\$6,500.00	\$13,000.00
HMO Gold 005 Zero Cost Sharing Plan Variation	\$0.00	\$0.00
HMO Gold 005 Limited Cost Sharing Plan Variation	\$6,500.00	\$13,000.00
HMO Bronze 008 High Deductible Health Plan Off Exchange	\$6,750.00	\$13,500.00
HMO Bronze 008 High Deductible Health Plan	\$6,750.00	\$13,500.00
HMO Bronze 008 Zero Cost Sharing Plan Variation	\$0.00	\$0.00
HMO Bronze 008 Limited Cost Sharing Plan Variation	\$6,750.00	\$13,500.00
HMO Silver 009 Off Exchange	\$7,000.00	\$14,000.00
HMO Silver 009	\$7,000.00	\$14,000.00
HMO Silver 009 Zero Cost Sharing Plan Variation	\$0 .00	\$0 .00
HMO Silver 009 Limited Cost Sharing Plan Variation	\$7,000.00	\$14,000.00
HMO Silver 009 94	\$2,500.00	\$5,000.00
HMO Silver 009 87	\$2,700.00	\$5,400.00
HMO Silver 009 73	\$6,000.00	\$12,000.00

## Penalty for Brand When Generic Available

Community Health Choice requires members to use generic medications when a generic is available. If a brand name drug is dispensed when a generic is available (multi-source brand), the member will pay the applicable copay plus the cost difference between the brand and generic, regardless if the doctor's prescription indicates the branded medication should be dispensed. This amount will not apply to the member's maximum out-of-pocket.

## Mail Order Service

The Mail Order Service allows you to receive up to a 90-day supply of maintenance medications. Not all maintenance medications are available via mail order service. This program is part of your pharmacy benefit and is **voluntary**.

### Mail Service In-Network Pharmacy 90 Days Supply

Group	Copay Amount		
	Tier 1 Generic and lower cost brand products	Tier 2 Preferred brand and higher cost generics	Tier 3 Non preferred brand (could include both brand and generic products)
HMO Bronze 003 Off Exchange	\$37.5 All Tier 1 generics bypass deductible	\$175 After deductible	\$300 After deductible
HMO Bronze 003	\$37.5 All Tier 1 generics bypass deductible	\$175 After deductible	\$300 After deductible
HMO Bronze 003 Zero Cost Sharing Plan Variation	\$0	\$0	\$0
HMO Bronze 003 Limited Cost Sharing Plan Variation	\$37.5 All Tier 1 generics bypass deductible	\$175 After deductible	\$300 After deductible
	\$0 when filled through an Indian Health Service Provider		
HMO Silver 004 Off Exchange	\$25 All Tier 1 generics bypass deductible	\$150 After deductible	\$250 After deductible
HMO Silver 004	\$25 All Tier 1 generics bypass deductible	\$150 After deductible	\$250 After deductible
HMO Silver 004 Zero Cost Sharing Plan Variation	\$0	\$0	\$0

HMO Silver 004 Limited Cost Sharing Plan Variation	\$25 All Tier 1 generics bypass deductible	\$150 After deductible	\$250 After deductible
	\$0 when filled through an Indian Health Service Provider		
HMO Silver 004 94	\$12.50	\$50	\$100
HMO Silver 004 87	\$25	\$125.00	\$212.50
HMO Silver 004 73	\$25 All Tier 1 generics bypass deductible	\$125 After deductible	\$225 After deductible
HMO Gold 001 Off Exchange	\$50.00	\$100	\$200
HMO Gold 001	\$50.00	\$100	\$200
HMO Gold 001 Zero Cost Sharing Plan Variation	\$0	\$0	\$0
HMO Gold 001 Limited Cost Sharing Plan Variation	\$50.00	\$100	\$200
	\$0 when filled through an Indian Health Service Provider		
HMO Gold 005 Off Exchange	\$25 All Tier 1 generics bypass deductible	\$100 After deductible	\$175 After deductible
HMO Gold 005	\$25 All Tier 1 generics bypass deductible	\$100 After deductible	\$175 After deductible
HMO Gold 005 Zero Cost Sharing Plan Variation	\$0	\$0	\$0
HMO Gold 005 Limited Cost Sharing Plan Variation	\$25 All Tier 1 generics bypass deductible	\$100 After deductible	\$175 After deductible
	\$0 when filled through an Indian Health Service Provider		
HMO Bronze 008 High Deductible Health Plan Off Exchange	No charge after deductible	No charge after deductible	No charge after deductible
HMO Bronze 008 High Deductible Health Plan	No charge after deductible	No charge after deductible	No charge after deductible
HMO Bronze 008 Zero Cost Sharing Plan Variation	\$0	\$0	\$0
HMO Bronze 008 Limited Cost Sharing Plan Variation	No charge after deductible	No charge after deductible	No charge after deductible

HMO Silver 009 Off Exchange	\$37.50 All Tier 1 generics bypass deductible	\$175 After deductible	\$300 After deductible
HMO Silver 009	\$37.50 All Tier 1 generics bypass deductible	\$175 After deductible	\$300 After deductible
HMO Silver 009 Zero Cost Sharing Plan Variation	\$0	\$0	\$0
HMO Silver 009 Limited Cost Sharing Plan Variation	\$37.50 All Tier 1 generics bypass deductible	\$175 After deductible	\$300 After deductible
HMO Silver 009 94	\$12.50	\$50	\$100
HMO Silver 009 87	\$25	\$125.00	\$212.50
HMO Silver 009 73	\$25 All Tier 1 generics bypass deductible	\$125 After deductible	\$250 After deductible

### RxCENTS (Savings Enabled Tablet Splitting)

Through this program, members pay only one-half of their usual copayment on a select group of prescription drugs. This program is part of your pharmacy benefit and is **voluntary**.

### Specialty Pharmacy

Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

#### Specialty In-Network Pharmacy 1-30 Days Supply

Group	Coinsurance Amount
HMO Bronze 003 Off Exchange	45% coinsurance after deductible
HMO Bronze 003	45% coinsurance after deductible
HMO Bronze 003 Zero Cost Sharing Plan Variation	\$0
HMO Bronze 003 Limited Cost Sharing Plan Variation	45% coinsurance after deductible \$0 when filled through an Indian Health Service Provider
HMO Silver 004 Off Exchange	45% coinsurance after deductible
HMO Silver 004	45% coinsurance after deductible
HMO Silver 004 Zero Cost Sharing Plan Variation	\$0
HMO Silver 004 Limited Cost Sharing Plan Variation	45% coinsurance after deductible \$0 when filled through an Indian Health Service Provider
HMO Silver 004 94	20% coinsurance



HMO Silver 004 87	30% coinsurance
HMO Silver 004 73	40% coinsurance after deductible
HMO Gold 001 Off Exchange	30% coinsurance
HMO Gold 001	30% coinsurance
HMO Gold 001 Zero Cost Sharing Plan Variation	\$0
HMO Gold 001 Limited Cost Sharing Plan Variation	30% coinsurance \$0 when filled through an Indian Health Service Provider
HMO Gold 005 Off Exchange	30% coinsurance after deductible
HMO Gold 005	30% coinsurance after deductible
HMO Gold 005 Zero Cost Sharing Plan Variation	\$0
HMO Gold 005 Limited Cost Sharing Plan Variation	30% coinsurance after deductible \$0 when filled through an Indian Health Service Provider
HMO Bronze 008 High Deductible Health Plan Off Exchange	\$0 after deductible
HMO Bronze 008 High Deductible Health Plan	\$0 after deductible
HMO Bronze 008 Zero Cost Sharing Plan Variation	\$0
HMO Bronze 008 Limited Cost Sharing Plan Variation	\$0 after deductible
HMO Silver 009 Off Exchange	45% coinsurance after deductible
HMO Silver 009	45% coinsurance after deductible
HMO Silver 009 Zero Cost Sharing Plan Variation	\$0
HMO Silver 009 Limited Cost Sharing Plan Variation	45% coinsurance after deductible \$0 when filled through an Indian Health Service Provider
HMO Silver 009 94	20% coinsurance
HMO Silver 009 87	30% coinsurance
HMO Silver 009 73	45% coinsurance after deductible

### **Vaccination Program**

Navitus Vaccination Program allows members to receive select vaccinations at participating in-network pharmacies at \$0.00 copay. This program is part of your pharmacy benefit and is **voluntary**.

### **Exclusions**

This is a partial list of limitations and exclusions. A complete list is available in the Evidence Of Coverage And Member Handbook, the document upon which benefit payments will be determined. This document is available on the Community Health Choice web site, [www.CommunityCares.com](http://www.CommunityCares.com).

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

1. Drugs which are not included on the Drug Formulary
2. Legend (prescription) drugs which are not deemed Medically Necessary by the qualified health plan
3. Any drug considered Experimental, investigational or for research purposes, even though a charge is made to the Covered Person

4. Therapeutic devices or appliances, except as expressly provided in the Evidence Of Coverage and Member Handbook (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 Community Health Choice Health Insurance Marketplace
  - b. Support garments
  - c. Mechanical pumps for delivery of medication
  - d. Other non-medical substances
5. Anorectic or any drug used for the purpose of Weight control
6. Any drug used for cosmetic purposes.
7. Medications filled without a prescription
8. Infertility services including medications
9. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra
10. Prescription refills:
  - a. In excess of the number specified by the Healthcare Practitioner
  - b. Dispensed more than one year from the date of the original order
11. Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained
12. Any drug, medicine or medication received by the Covered Person:
  - a. Before becoming covered under this benefit
  - b. After the date the Covered Person's coverage has ended
13. Any costs related to the mailing, sending or delivery of Prescription Drugs
14. Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health practitioner from providing or performing the procedure, treatment or supply; however, the procedure, treatment will not be a covered expense.

# FILLING YOUR PRESCRIPTION



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## **Filling Your Prescription at a Network Pharmacy**

The first step to filling your prescription is deciding on a participating pharmacy. In most cases, you can still use your current pharmacy. There is a complete list on the member website. Information on how to access the member website can be found in the Frequently Asked Questions section of this booklet.

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## **Using Your Medical Benefit ID Card**

You will not need a separate pharmacy benefit ID card. Your medical benefit card also contains information about your pharmacy benefit. Please present your medical benefit card to the pharmacy when you refill your prescription. To determine your copayment before going to the pharmacy, call customer care toll-free.

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## **Receiving Your Medications Through Mail Order**

Our mail order service offers an easy way for you to get your long-term or maintenance medications. Your prescriptions are delivered to your door, saving you a trip to the pharmacy. For more information on how to start our mail order service visit **[www.navitus.com](http://www.navitus.com)** > **Members** > **Member Login** or contact Navitus customer care.

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## **Submitting a Claim**

In an emergency, you may need to request reimbursement for prescriptions that you have filled and paid for yourself. To submit a claim, you must provide specific information about the prescription, the reason you are requesting reimbursement, and any payments made by primary insurers. Complete the appropriate claim form and mail it along with the receipt to:

Navitus Health Solutions  
Operations Division - Claims  
P.O. Box 999,  
Appleton, WI 54912-0999

Claim forms are available on the member website or by calling customer care.

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# FORMULARY FACTS



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## About Drug Formularies

The formulary is a comprehensive list of preferred drugs chosen based on quality and efficacy by a committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying which drugs are covered. It is updated regularly and includes brand name and generic drugs.

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## Selecting Drugs for Your Formulary

An independent group of physicians and pharmacists meets regularly during the year to review and select drugs for your formulary that will be safe, effective and affordable. The committee assesses drugs based on their therapeutic value, side effects and cost compared to similar medications. Based on the committee's review of new and existing drugs, your formulary is evaluated to ensure it is up to date.

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## Checking Your Formulary

Your formulary is on the Navitus website through your member portal. You can access your member portal by going to **[www.navitus.com](http://www.navitus.com) > Members > Member Login**. You may search the formulary for a specific drug. You can also browse alphabetically or by category of use. Also included is information about which drug products need prior authorization and/or have quantity limits. The formulary is a condensed list and does not list every covered drug. The coverage or tier for each drug product is noted on the formulary, but the dollar amount you pay for each medication is not listed. See the Pharmacy Benefit Schedule included in this booklet for more information, including the cost share amount you pay for each drug.

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## Changes to Your Formulary

Your formulary is evaluated on an ongoing basis, and could change. Navitus does not send separate notices if a brand-name drug becomes available as a generic drug. The pharmacist usually tells you this information when you fill your next prescription. If you have more questions about the formulary or your cost share, please contact Navitus Customer Care.

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# MAIL ORDER



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## Getting Your Prescriptions Through Mail Order

Navitus Health Solutions partners with Postal Prescription Services (PPS), a subsidiary of The Kroger Co., to offer mail order services. Prescriptions covered as part of your pharmacy benefit are available through mail order. We recommend using mail order for maintenance (long-term) drugs only. We recommend using a retail pharmacy for drugs needed on a short-term basis (e.g., antibiotics for a short-term illness).

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### It's Easy to Start:

#### ***Step 1: Enroll***

Complete the mail order enrollment process online at **www.ppsrx.com**. You may also contact PPS Customer Care by phone. They can be reached toll-free at 1-800-552-6694.

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#### ***Step 2: Fill Your Prescription***

Mail the original prescription to PPS with your enrollment form, or have your health care provider send the prescription directly to PPS. Your provider can send the prescription to PPS through the following options:

- **Online:** [www.ppsrx.com](http://www.ppsrx.com)
- **Call:** 1-800-552-6694
- **Fax:** 1-800-723-9023
- **Mail:** PPS Prescription Services, P.O. Box 2718  
Portland, OR 97208-2718
- **E-prescribe:** NABP 3812674

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#### ***Step 3: Complete Payment***

You can make your copayment by phone at 1-800-552-6694 or by mail. PPS accepts personal checks, money orders and most major credit cards.

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### Obtaining Refills

After receiving your first mail order prescription, you can order refills using any of the following methods:

- **Online:** [www.ppsrx.com](http://www.ppsrx.com)
- **Call:** 1-800-552-6694

Customer Service hours are Monday-Friday, 6am-6pm PST  
and Saturday, 9am-2pm PST.



### **Opt-in to the Refill Reminder Program**

You can call PPS to opt-in to the refill reminder program once you have a prescription set up.

- Call PPS at 1-800-552-6694 and tell them that you would like to opt-in to the refill reminder program
- Tell the representative if you prefer text or email notifications
- Once set up, you will receive a refill reminder with the last four digits of the prescription(s) due to be refilled
- Call PPS at 1-800-552-6694 or **visit [ppsrx.com](https://ppsrx.com)** to refill the prescription(s)
- Prescription refills will be shipped within 24-48 hours

Please allow 7-10 days to receive your prescription. Prescriptions cannot be mailed to locations outside of the United States. Exceptions include U.S. territories, protectorates and military installations.

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# FREQUENTLY ASKED QUESTIONS



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## **What is Navitus?**

Navitus Health Solutions is your Pharmacy Benefits Manager (PBM).

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## **What is a Pharmacy Benefit Manager?**

A PBM directs prescription drug programs and processes prescription claims by negotiating drug costs with manufacturers, contracting with pharmacies and building and maintaining drug formularies. These cost-saving strategies help lower drug costs and promote good member health.

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## **Who should I contact with questions or problems outside of the normal Customer Care business hours? Who should my pharmacist contact?**

Your preferred drug list, list of participating pharmacies and other information about your pharmacy benefit can be found on **www.navitus.com** through the member portal, Navi-Gate for Members®. You can also call Navitus Customer Care toll-free at 1-866-333-2757 with questions about your pharmacy benefit.

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## **Where can I find my formulary?**

The list of drugs covered by your benefit is available on our website at **www.navitus.com >Members>Member Login**.

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## **Can I use my health plan card to fill prescriptions at my pharmacy?**

Yes, Community Health Choice has provided you with a combined medical/prescription drug ID card. Present your Community Health Choice ID card when filling prescriptions at your pharmacy and at all medical appointments. You can request replacement cards from Community Health Choice by calling Customer Care toll-free at 1-855-315-5386.

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## **Who do I call to change my ID card information?**

Please call Community Health Choice toll-free at 1-855-315-5386 if any information on your ID card needs to be changed. A new ID card will be mailed to you, and you should receive it within 7-10 calendar days from the date of your request.

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### **How do I fill a prescription when I travel for business or vacation?**

If you are traveling for less than one month, any Navitus Network Pharmacy can arrange in advance for you to take an extra one-month supply. A copay will apply.

If you are traveling for more than one month, you can request that your pharmacy transfer your prescription order to another network pharmacy located in the area where you will be traveling. Visit **www.navitus.com** for instructions on filling prescriptions while traveling. Or contact Customer Care toll-free at 1-866-333-2757.

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### **Can prescriptions be mailed to me if I'm outside of the United States?**

No, prescriptions cannot legally be mailed from the mail order pharmacy or any pharmacy in the United States to locations outside of the country, except for U.S. territories, protectorates and military installations.

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### **How do I use the Navitus SpecialtyRx program?**

Navitus SpecialtyRx works with Lumicera Health Services to offer services with the highest standard of care. You will get one-on-one service with skilled pharmacists. They will answer questions about side effects and give advice to help you stay on course with your treatment. With Navitus SpecialtyRx, delivery of your specialty medications is free, and right to your door or prescriber's office via a variety of shipping methods depending on the requirements of the medication you are taking. Overnight priority is available or required for some medications. To start using Navitus SpecialtyRx, please call toll-free 1-855-847-3553. We will work with your prescriber for current or new specialty prescriptions.

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### **How does the RxCENTS (Tablet Splitting) program work?**

There are two ways to get started with the Tablet Splitting program:

1. Call your doctor and ask about the RxCENTS program. He or she can update your prescription with your pharmacy.
2. Ask your pharmacist to help change your prescription to one that can be split through the Navitus Tablet Splitting program.

Tablet splitting is not required by Navitus, but is simply offered as a way to help control costs. If you have any questions, or would like a tablet splitter, please contact Navitus customer care toll-free at 1-866-333-2757.

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### **How do I make a complaint or file an appeal?**

When you have a concern and need to make a complaint or file an appeal, contact Community Health Choice at 1-713-295-6704 or 1-855-315-5386. If your issue or concern is not resolved by calling Community Health Choice, you have the right to file a written appeal with Community Health Choice. Please send this appeal, along with related information from your doctor to:

**MAIL** Community Health Choice, Inc.  
Attn: Appeals Coordinator  
2636 South Loop West, Suite 125  
Houston, TX 77054

**FAX** Community Health Choice, Inc.  
713-295-7033  
Attn: Appeals Coordinator

## 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 1.855.315.5386.
2. Chinese	本通知有重要信息。本通知包含關於您透過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採取行動，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 1.855.315.5386.
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 1.855.315.5386.
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 1.855.315.5386.
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 1.855.315.5386.
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. 1.855.315.5386 પર કોલ 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 के लिए खोजिये। आप अपने स्वास्थ्यके कवरेज रखने के लिए या लागत के मदद के लिए निश्चित समय सीमासे कार्रवाई करना जरूरत हो सकती है। आपको अपनी भाषा में इस जानकारी और सहायता निःशुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 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。1.855.315.5386 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. 1.855.315.5386로 연락하십시오.
10. Laotian	ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບໃບສະໜັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນອື່ນທີ່ສໍາຄັນໃນໜັງສືແຈ້ງການນີ້.ທ່ານອາດຈະຕ້ອງປະຕິບັດຜ່ານໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອໃນເຮືອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ 1.855.315.5386.
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 نگه داشتن 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 1.855.315.5386 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: 1.855.315.5386.



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 1.855.315.5386.
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 1.855.315.5386.
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 کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہو سکتی ہے۔ آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے۔ 1.855.315.5386 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 1.855.315.5386.

**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 1.855.315.5386. If you believe that Community Health Choice, Inc. has failed to provide these services or discriminated in another way on this basis of race, color, national origin, age, disability or sex, you can file a grievance.

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

Privacy Officer Name: Corporate Compliance & Risk Management  
2636 South Loop West, Suite 125  
Houston, Texas 77054  
**Phone:** 713.295.2200  
**Email:** Compliance@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  
1.800.369.1019, 900.537.7697



# COMMON TERMS

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**Brand Drug**

A drug with a proprietary, trademarked name, protected by a patent by the U.S. Food and Drug Administration (FDA). The patent allows the drug company to exclusively market and sell the drug for a period of time. When the patent expires, other drug companies can make and sell a generic version of the brand-name drug.

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**Copayment/Coinsurance**

Refers to that portion of the total prescription cost that the member must pay.

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**Deductible**

Member pays 100% of the cost of each prescription up to a pre-specified dollar amount, at which point the prescription drug benefit takes effect.

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**Formulary**

A list of drugs that are covered under your benefit plan.

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**Generic Drugs**

Prescription drugs that have the same active ingredients, same dosage form and strength as their brand-name counterparts.

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**Out-of-Pocket Maximum**

The maximum dollar amount the member can pay per contract year.

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**Over-the-Counter Medication**

A drug you can buy without a prescription.

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**Prescription Drug**

Any drug you may get by prescription only.

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**Prior Authorization**

Approval from Navitus for coverage of a prescription drug.

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**Specialty Drug**

Drugs, such as self-injectables and biologics, typically used to treat patients with chronic illnesses or complex diseases.

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**Therapeutic Equivalent**

Similar drug in the same drug classification used to treat the same condition.

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Voice your feedback, concerns or complaints, or report errors regarding your prescription drug benefit. We welcome your input and want to hear and act on this information with a polite and quick response. Ensuring quality and safe care, correcting errors and preventing future issues are top priorities.

For a copy of your member rights and responsibilities, please visit your member website or call the customer care number listed below.

Navitus does not discriminate on the basis of disability in the provision of programs, services or activities. If you need this printed material interpreted or in an alternative format, or need assistance using any of our services, please contact Navitus Customer Care at 1-866-333-2757 (toll-free) or 711 (TTY).

# LANGUAGE ASSISTANCE

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



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## NON-DISCRIMINATION STATEMENT MARKETPLACE

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, 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. Member Services Department at 1.855.315.5386. 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.

You can file a grievance in person or by mail, fax or email:

**Service Improvement Department**

2636 South Loop West, Suite 125  
Houston, Texas 77054

**Phone:** 1.855.315.5386

**Email:** [ServiceImprovement@CommunityHealthChoice.org](mailto:ServiceImprovement@CommunityHealthChoice.org)

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)

<b>Chinese</b>	本通知有重要信息。本通知包含關於您透過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採取行動，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1.855.315.5386。
<b>French</b>	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 1.855.315.5386.
<b>Gujarati</b>	આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વર્ણિ 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 વગર તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.855.315.5386 પર કોલ કરો.
<b>Japanese</b>	こと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。1.855.315.5386までお電話ください。
<b>Laotian</b>	ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັກໜີງການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີ່ສໍາຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍຫຼັງການຊ່ວຍເຫຼືອໃນເລື່ອງຕ່າງໆ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໂດຍບໍ່ເສັຍສ່ຳຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.
<b>Russian</b>	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: 1.855.315.5386.
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<b>Arabic</b>	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 على تأمينك الصحي أو مساعدتك في دفع التكاليف. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل على 1.855.315.5386.
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<b>Hindi</b>	इस सूचना में महत्वपूर्ण जानकारी है। इस सूचना में आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूर्ण जानकारी है। इस सूचना में महत्वपूर्ण तारीखों के लिए खोजें। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चित समय सीमा से कार्रवाई करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता नि:शुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 पर कॉल कीजिए।
<b>Korean</b>	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. 1.855.315.5386로 연락하십시오.
<b>Persian</b>	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 1.855.315.5386 تماس بگیرید.
<b>Spanish or Spanish Creole</b>	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 1.855.315.5386.
<b>Urdu</b>	اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں Community Health Choice کے ذریعے آپ کی درخواست یا بیمے کی 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 کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہیں۔ آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے۔ 1.855.315.5386 پر رابطہ کریں۔

# LANGUAGE ASSISTANCE

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



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## NON-DISCRIMINATION STATEMENT MARKETPLACE

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, 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. Member Services Department at 1.855.315.5386. 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.

You can file a grievance in person or by mail, fax or email:

**Service Improvement Department**

2636 South Loop West, Suite 125  
Houston, Texas 77054

**Phone:** 1.855.315.5386

**Email:** [ServiceImprovement@CommunityHealthChoice.org](mailto:ServiceImprovement@CommunityHealthChoice.org)

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)

<b>Chinese</b>	本通知有重要信息。本通知包含關於您透過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採取行動，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1.855.315.5386。
<b>French</b>	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 1.855.315.5386.
<b>Gujarati</b>	આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વર્ણિ 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 વગર તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.855.315.5386 પર કોલ કરો.
<b>Japanese</b>	こと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。1.855.315.5386までお電話ください。
<b>Laotian</b>	ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັກໜີງການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີ່ທີ່ສໍາຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍຫຼັງການຊ່ວຍເຫຼືອໃນເລື່ອງຕໍາ໊ຈ້າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນສໍາຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.
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<b>Hindi</b>	इस सूचना में महत्वपूर्ण जानकारी है। इस सूचना में आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूर्ण जानकारी है। इस सूचना में महत्वपूर्ण तारीखों के लिए खोजें। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चित समय सीमा से कार्रवाई करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता नि:शुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 पर कॉल कीजिए।
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<b>Persian</b>	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 1.855.315.5386 تماس بگیرید.
<b>Spanish or Spanish Creole</b>	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 1.855.315.5386.
<b>Urdu</b>	اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں Community Health Choice کے ذریعے اپ کی درخواست یا بیمے کی 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 کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہیں۔ آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے۔ 1.855.315.5386 پر رابطہ کریں۔