PHARMACY BENEFIT SCHEDULE

Benefit Effective Date	Benefit Type
January 1, 2020	Health Insurance Marketplace

	Retail In-Network Pharmacy 1-30 Days' Supply			Retail In-Network Pharmacy 90 Days' Supply		
Group	**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.

Group	Individual OOP Amount	Family OOP Amount
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			
	Copay Amount		
Group	**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 an 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.

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.

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

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

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)

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1.855.315.5386。
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.
Gujarati	આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને 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 કૉલ કરો.
Japanese	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。
Laotian	ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນອັນທີ່ທີ່ສຳຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍໜັງການຊ່ວຍເຫຼືອໃນເລື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນສຳຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.
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.
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.
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 gian 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 mình miễn phí. Xin gọi 1.855.315.5386.
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 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.
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.
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 Ma nahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.855.315.5386.
Hindi	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 खोजयिे। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चित समय सीमा से कार्रवाइ करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता नःशुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 पर कॉल कीजिए।
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.
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 با 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 تلفن1.855.315.5386 . تماس بگیرید.
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.
Urdu	اس نوٹس میں اہم معلومات ہیں. اس نوٹس میں Community Health Choice کے ذریعے اپ کی درخواست یا بیمے کی تحفظ سے متعلق اھم 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.

P.O. Box 301424
Houston, TX 77230-1424

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

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

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)

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1.855.315.5386。
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.
Gujarati	આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને 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 કૉલ કરો.
Japanese	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。
Laotian	ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນອັນທີ່ທີ່ສຳຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍໜັງການຊ່ວຍເຫຼືອໃນເລື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນສຳຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.
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.
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.
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 gian nhất định để giử 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 mình miễn phí. Xin gọi 1.855.315.5386.
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 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.
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.
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Hindi	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 खोजयिे। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चित समय सीमा से कार्रवाइ करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता नःशुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 पर कॉल कीजिए।
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Urdu	اس نوٹس میں اہم معلومات ہیں. اس نوٹس میں Community Health Choice کے ذریعے اپ کی درخواست یا بیمے کی تحفظ سے متعلق اھم 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.

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