Small Group Master Application – Oregon

For groups of 1-50 employees

PacificSource HEALTH PLANS

Employer Information

Legal Name of Group _____ Effective Date _____

DBA Name (appears on bills and ID cards) _____ SIC or NAICS Code _____

Physical Address Required (no PO Box) _____

City _____ State _____ ZIP _____ County _____

Mailing Address (if different than physical address) _____

City _____ State _____ ZIP _____ County _____

Federal Tax ID No. _____ Company Headquarters State _____ Nature of Business _____

Name(s) of All Owners and Partners _____

Form of Organization
(check all that apply)

- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Subchapter S-Corp
- ☐ Government
- ☐ Partnership
- ☐ Association
- ☐ Nonprofit
- ☐ C-Corp
- ☐ MEWA
- ☐ Church
- ☐ Union
- ☐ Trust

Group Contacts

Group Contact _____ Phone _____ Email _____ Fax _____

Billing Contact _____ Phone _____ Email _____ Fax _____

Affiliates (to add more contacts, please attach additional pages)

Is your company affiliated with any other? ☐ Yes ☐ No **Will it be insured with PacificSource?** ☐ Yes, Common Ownership Form is attached ☐ No

Name of Affiliate(s) _____ No. of Employees _____

Address of Affiliate(s) _____ Should each affiliate be billed separately? ☐ Yes ☐ No

Current Insurance (required if you had prior coverage)

Medical

Carrier _____

Policy No. _____

Term Date _____

Dental

Carrier _____

Policy No. _____

Term Date _____

Who was eligible for your prior dental plan?

☐ Children Only ☐ Adults and Children

Existing Workers' Compensation

Carrier _____

Policy No. _____

Medical Benefit Information

The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the ACA for small groups. Pediatric dental care is available in the market and can be purchased as a standalone product. Contact your agent or let your PacificSource representative know if you wish to purchase a standalone dental care product.

Please select no more than four plans for your group members to choose from. Need some guidance? Please contact your sales representative with questions.

Navigator

- ☐ Platinum 500
- ☐ Gold 1000
- ☐ Gold 2000
- ☐ Gold 2500
- ☐ Gold 3500
- ☐ Silver 3000
- ☐ Silver 4500
- ☐ Silver 5500
- ☐ Silver 6500
- ☐ Bronze 8150
- ☐ Gold HSA 3000
- ☐ Silver HSA 3000
- ☐ Silver HSA 4500
- ☐ Silver HSA 5500
- ☐ Bronze HSA 7000
- ☐ Standard Gold
- ☐ Standard Silver
- ☐ Standard Bronze

Voyager

- ☐ Platinum 500
- ☐ Gold 1000
- ☐ Gold 2000
- ☐ Gold 2500
- ☐ Gold 3500
- ☐ Silver 3000
- ☐ Silver 4500
- ☐ Silver 5500
- ☐ Silver 6500
- ☐ Bronze 8150
- ☐ Gold HSA 3000
- ☐ Silver HSA 3000
- ☐ Silver HSA 4500
- ☐ Silver HSA 5500
- ☐ Bronze HSA 7000
- ☐ Standard Gold
- ☐ Standard Silver
- ☐ Standard Bronze

Dental Benefit Information

- ☐ Dental Choice 0-20-50 50-1000
- ☐ Dental Choice Plus 0-20-50 25-1000
- ☐ Dental Choice Plus 0-20-50 25-1500
- ☐ Dental Choice Plus 0-20-50 50-1000
- ☐ Dental Choice Plus 0-20-50 50-1500
- ☐ Dental Advantage Core
- ☐ Dental Advantage 20-20-50 1000
- ☐ Dental Advantage 20-20-50 1500
- ☐ Dental Advantage 0-20-50 1000
- ☐ Dental Advantage 0-20-50 1500
- ☐ Dental Advantage Plus 0-20-50 1000
- ☐ Dental Advantage Plus 0-20-50 1500
- ☐ Kids Dental Advantage 0-20-50 (for members through the age of 18)
- ☐ Kids Dental Advantage 20-40-50 (for members through the age of 18)
- ☐ Cosmetic Orthodontia (minimum enrollment requirements)

Billing Structure/SHOP Eligibility

Billing Structure: ☐ Tiered rates (based on family composition)

☐ Small Business Health Options Program (SHOP) enrollment. *If yes, please complete the state-specific SHOP eligibility form.*

Employer Premium Contribution (the amount the employer will contribute toward the employee and dependent premium)

Medical: ☐ % ☐ $ Employee _____ Dependent _____

Dental: ☐ % ☐ $ Employee _____ Dependent _____

Eligibility

Probationary Waiting Period

☐ Date of hire (premium prorated first month)
☐ First of the month following date of hire
☐ First of the month following 30 days
☐ First of the month following 60 days
☐ 90 calendar days effective on 91st calendar day (premium prorated first month)
☐ Other _____

If the last day of the probationary period falls on the first day of the month, when will the new employee's eligibility be effective?

☐ Eligible that day
☐ Must wait until the first day of the following month or 91st day, whichever comes first (default if not marked)

Initial Enrollment: Will the probationary period be waived at initial enrollment? ☐ Yes ☐ No

Minimum Hours

How many hours per week must employees work to be eligible for coverage?

Hours per week _____

Eligible Members

Plan covers:

☐ Employee + spouse/domestic partner + children
☐ Employee only

HSA, HRA, FSA, COBRA Administration, EAP, or POP

Check accounts your group has ☐ HSA ☐ HRA ☐ FSA ☐ COBRA Admin ☐ EAP ☐ POP

Employer Contribution to HRA or HSA _____

Third Party Administrator Name _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ Email _____

People to Be Insured

1. _____ Total number of employees (full-time, part-time, owner, partner, principal, probationary, and waiver; exclude continuation)
2. _____ Total number of former employees currently on Continuation or Retiree with your group health plan (submit Employee Enrollment and Waiver Form)

A. _____ TOTAL NUMBER OF EMPLOYEES: Add numbers 1 and 2 above

3. _____ Total number of employees who do not qualify due to hourly requirement
4. _____ Total number of employees who do not qualify due to waiting period requirement
5. _____ Total number of employees waiving coverage due to other qualified coverage* (submit Employee Enrollment and Waiver Form)
   **Qualified Coverage: Employer Plan, Medicare, Medicaid, VA/Tricare, and Indian Health Service*
6. _____ Total number of employees not insured for reasons not stated above
   Please explain reason (e.g., classification not eligible, chose not to participate): _____

B. _____ TOTAL NUMBER OF EMPLOYEES NOT ENROLLING: Add numbers 3 through 6 above

C. _____ TOTAL NUMBER OF EMPLOYEES ENROLLING, including continuation: Subtract B from A above

SERVICE AREA: Do all employees reside within the PacificSource service area? ☐ Yes ☐ No If no, what state(s): _____

ERISA: Is your group comprised of employees of a government entity or church that is **NOT** subject to ERISA? ☐ Yes ☐ No

Medicare Coordination (TEFRA): Did you employ 20 or more employees each working day each of the 20 or more calendar weeks in the **current or preceding calendar year**? ☐ Yes ☐ No

COBRA: Did you employ 20 or more total employees (full-time, part-time, seasonal) at least 50% of your business days in the **preceding calendar year**? ☐ Yes ☐ No

Employees on continuation of coverage (COBRA, State or USERRA):

Are any enrolling members covered under continuation on this plan? ☐ Yes ☐ No

If yes, Employee Enrollment and Waiver Form must be submitted for each employee on continuation.

RETIREE: Is group coverage available to retirees? ☐ Yes ☐ No Is the group a local government (school, city, county)? ☐ Yes ☐ No

Approval is dependent on PacificSource policy and approval. If you offer health or dental coverage to your retirees, please attach the requirements and employer premium contribution if any.

Requirements—must be submitted prior to policy effective date

- ☐ Group Master Application
- ☐ Copy of Sold Rates
- ☐ Member Employee Enrollment and Waiver Information
- ☐ Binder Payment (estimated first month premium) *Refunded if coverage not effectuated*
- ☐ Electronic Funds Transfer Form, if you want PacificSource to withdraw the monthly premium from a bank account
- ☐ Common Ownership Form, if applicable
- ☐ Group Identification Form, if applicable

This is an application for group insurance. Under no circumstances will coverage be in force until the policy is issued by PacificSource and accepted by the employer. Once a policy is issued, the policy terms control in all cases.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.

Group Representative (printed) _____ **Title** _____

Group Representative Signature _____ **Date** _____

I, the undersigned producer for this group, affirm that the information provided on this application is complete and correct to the best of my knowledge.

Producer Name (printed) _____ **PacificSource Producer Number** _____

Producer Signature _____ **Date** _____

What happens next?

1. You'll get an email with information to help you administer the plan.
2. You'll get the contract and a handbook in the mail.
3. We'll send your employees their ID cards.

If additional information is needed, a PacificSource representative will contact you. Please keep a copy of this application for your records.

Discrimination is Against the Law

PacificSource Health Plans ("PacificSource") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY: 711, Fax (541) 684-5264, or email CRC@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department is available to help you.

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)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Amharic	ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የPacificSource Health Plans ሽፋን አስፈላጊ መረጃ አለው።በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (888) 977-9299 ይደውሉ።
Arabic	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال PacificSource Health Plans ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك (888) 977-9299 من دون أي تكلفة. اتصل بـ

Bantu-Kirundi	Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye PacificSource Health Plans, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara (888) 977-9299.
Cambodian-Mon-Khmer	បសចកតីជូនំណឹងបនេះ មួនព័ែ៌មួនយា៉ាំ ងសំខាន់ ។ បសចកតីជូនំណឹងបនេះ មួនព័ែ៌មួនយា៉ាំ ងសំខាន់ អុំពីេបួង់ដររេ ឬ ការរ៉ា រ់ង រស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលរិបចេេសំខាន់ចាំថ់ បៅកនុងបសចកតីជូនំណឹងបនេះ ។ អ្នកប្រដែលជាបុ់េូវការរបចេញសកមមភាព េល់កំណៃ់ថ្ងៃជាក់ចាស់នានា បែេើមបីនឹងរកាេុកការរ៉ា រ់ង សុខភាពរស់អ្នក ឬបុ់ាក់ជំនួយបចញថ្ងៃ ។ អ្នកមួនសិេធិេេួលព័ែ៌មួនបនេះ និងជំនួយបៅកនុងភាសារស់អ្នកបោយមិនអ៊្យលុយបេើយ ។ សូមេូរស័ពទ (888) 977-9299[។
Chinese	本通知含有重要的訊息。本通知對於您透過 PacificSource Health Plans 所提出的申請或保險有重要的訊息。請在本通知中查看重要的日期。您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢。您有權利免費以您的母語得到幫助和訊息 請致電 (888) 977-9299。
Cushite-Oromo	Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa PacificSource Health Plans tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa (888) 977-9299 tii bilbilaa.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de PacificSource Health Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (888) 977-9299.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch PacificSource Health Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (888) 977-9299.
Italian	Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso PacificSource Health Plans. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama (888) 977-9299.
Japanese	この通知には重要な情報が含まれています。この通知には、PacificSource Health Plans 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。(888) 977-9299までお電話ください。

Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 리가 있습니다. (888) 977-9299 로 전화하십시오.
Laotian	ການແຈ້ງການນ້ ມ່ຂ້ ມູ ນ່ສາຄັ ນ. ການແຈ້ງການນ້ ມ່ຂ້ ມູ ນ່ທ່ສາຄັ ນກ່ ງວກັ ບ່ຄາຮ້ ອງສະໝັ ກຫ ູ ີ ການຄ້ ມ ຄອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ເ ີ່ ບ່ງສາລັ ບກ່ ານົ ດວັ ນ່ທ ່ສາຄັ ນໃນແຈ້ ງການນ້ . ທ່ ານອາດ່ຈາເປັ ນຕ້ ອງໃຊ້ ເວລາ່ດາເນນການໂດຍກ່ ານົ ດເວລາ່ທແນ່ ນອນ ຈະ ຮັ ກສາການຄ້ ມຄອງສຂະພາບຂອງທ່ ານຫ ູ ີ ການຊ່ ວຍເຫ ູ ີ ອ່ທມຄ່ າໃຊ້ ຈ່ າຍ. ທ່ ານມີສດ່ທຈະໄດ້ ຮັ ບ່ຂ້ ມູ ນ ຂ່ າວສານນ້ ແລະການຊ່ ວຍເຫ ູ ີ ອໃນພາສາຂອງທ່ ານ່ທ່ບມຄ່ າໃຊ້ ຈ່ າຍ. ໂທ (888) 977-9299.
Nepali	यो स चनामा ू महत्त्वप र्ुू जानकारी छ । यो स चनामा ू तपाईकं ो आवे िन वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विबारे महत्त्वपर् ू ु जानकारी छ । यो सचू नामा भएका महत्त्वपर् ू ु दमदतहरू ख्याल िनुहु ोस् । तपाईलं े पाइरहके ो स्वास््य दबमा पाइरहन वा तपाईकं ो खचुको भक्तानीमा ुसहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईलं े यो जानकारी र सहायता आफ्नो मातभृ ाषामा दन शल्ु क पाउनु तपाईकं ो अदिकार: हो (888) 977-9299 मा फोन िनुहु ोस् ।
Norweigen	Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom PacificSource Health Plans. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helse-dekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt spark uten kostnad. Ring (888) 977-9299.
Pennsylvania Dutch	Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit PacificSource Health Plans. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (888) 977-9299 uffrufe
Persian	این اعلامیه حامی اطلاعات مهم میباشد. این اعلامیه حامی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما مربوط به PacificSource Health Plans به تاریخ های مهم در این اعلامیه توجه نمایید. شما . ممکن است تا به تاریخ های مشخصی برای حفظ پوشش مزایای یا برای کمک به مخارج مزایای ملزوم به انجام کارهایی شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید 9299-977 (888) باشید
Punjabi	ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿ ਾਰੇ ਮਹਿੱ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁ ਿ ੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਅੂੰ ਤਮ ਤਾਜਰਖ਼ ਤੋਂ ਪਜਹਲਾਂ ਕੁਿ ੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿ ੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫ਼ਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299
Romanian	Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin PacificSource Health Plans. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la (888) 977-9299.

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важнуюинформацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene 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 (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสาคัญประกาศนี้มีข้อมูลที่สาคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกาหนดการในประกาศนี้คุณอาจจะต้องดาเนินการภายในกาหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.