Individual and Family Enrollment Form
Montana

PacificSource HEALTH PLANS

Thank you for choosing PacificSource!

You may also enroll online at PacificSource.com.

What you'll need to complete this enrollment form:

- A blue or black pen.
- Information, such as your old ID card, from any insurance company that currently or recently covered you or your family. This information is needed to determine creditable coverage.
- A copy of any documentation you may need to show legal guardianship.
- Your health insurance producer's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).

You are eligible to enroll if:

- You and your dependents (if enrolling) are not receiving benefits under Medicare Part A, Medicare Part B, nor enrolled in a Medicare Choice or Advantage plan.
- You are a resident of the state of Montana.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- You or your legal spouse/domestic partner's children (if applicable) are your natural or adopted children, or you are their legal guardian.
- Your employer will not be paying, or reimbursing you, for any part of the premium. You could receive reimbursement if your employer offers an individual coverage Health Reimbursement Arrangement (ICHRA).

Please note: If you are eligible for federal financial assistance, you must apply for coverage at healthcare.gov.

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach us at **855-330-2792**.

What happens after you submit your application

We'll begin processing your application, and in the coming weeks, if you have met the qualifications and payment has been received, you'll receive a few things from us. To get information faster, include your email address in your application.

1. A Summary of Benefits and Coverage
2. New member information
3. Your ID card(s)
4. Your full policy

Please keep a copy of this application for your records.

This application is for PacificSource individual medical coverage. If you are intending to enroll in PacificSource dental-only coverage, please complete a dental-only Individual and Family Enrollment Form instead—available at PacificSource.com. To get started, go to the Shop Plans tab and click Dental.

1 What type of coverage would you like?

New Coverage

- ☐ For myself only
- ☐ For myself + my spouse/domestic partner
- ☐ For myself + my family
- ☐ For my child(ren) or legal dependent(s) only

Or

Change to My Current Coverage

Current PacificSource ID No. _____
(This can be found on your ID card.)

- ☐ Add family member(s) (Complete section 5)
- ☐ Change my plan as shown below

Coverage effective dates

Enrolling due to ☐ Qualifying event (please explain below) ☐ The open enrollment period

Qualifying event _____ Date of event _____/_____/_____

What date would you like the coverage to begin? _____/_____ Mo./Yr.

Documentation is required if enrolling outside of the open enrollment period, or adding dependents. If you apply during open enrollment, coverage will be effective January 1.

2 Choose a medical plan

For plan benefit information, please visit PacificSource.com or refer to our Montana Individual and Family Plan brochure.

Navigator

Available statewide:

- ☐ Gold 1500
- ☐ Silver 3000
- ☐ Silver 4000
- ☐ Silver 5000
- ☐ Bronze 7000
- ☐ Bronze 8700
- ☐ Silver HSA 3500
- ☐ Bronze HSA 7000

This policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Separate pediatric dental care policies are available in the market. Please contact your insurance agent, PacificSource, or your state's insurance exchange if you wish to purchase a stand-alone dental care policy. If you are attempting to purchase this plan outside of the exchange, you are not eligible to purchase this plan unless you currently have, or will obtain coverage with a qualified health plan (QHP)-certified pediatric dental plan with any carrier. This applies whether you are an adult or a child. We offer QHP-certified pediatric dental plans for which you are eligible to purchase through the exchange or directly with PacificSource. Please visit our website to review your options at PacificSource.com or contact your insurance agent for more information.

3 Choose a dental plan (If not enrolling in dental coverage, skip to next section.)

- ☐ Dental Choice 0-20-50 1000
- ☐ Dental Choice 0-20-50 1500
- ☐ Kids Dental Choice 0-20-50 (For members through age 18)

These policies include pediatric dental coverage that meets the requirements of the Affordable Care Act.

Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible. If a child is over the age of 26 and medically certified as disabled and dependent on parents, a copy of a certification is required.

*__Gender identity__ (optional): **A**-Agender, **B**-Boy, **GF**-Gender fluid, **GN-**Gender nonconforming, **GQ**-Genderqueer, **G**-Girl, **M**-Man, **NB**-Non-binary, **NL**-Not listed, **P**-Prefer not to answer, **Q**-Questioning or unsure, **TG**-Third gender, **TM**-Trans man, **TW**-Trans woman, **T**-Transgender, **TS**-Two-spirit, **W**-Woman

__Race/Ethnicity__ (optional): Choose the code that each family member would most closely identify with: **AI-American Indian/Alaska Native, **A**-Asian, **B**-Black/African American, **H**-Hispanic/Latino, **N**-Native Hawaiian/Other Pacific Islander, **W**-White/Caucasian.

***Use of tobacco on average four or more times per week within the past six months. Includes all tobacco products, except for religious or ceremonial use.

**** Not required for plan enrollment. Used for coordinating care with member's dedicated care team.

4 Myself (required)

If this is a child/dependent only policy, PacificSource requires the responsible parent or guardian to include their information.

Name (First, MI, Last) _____

Sex Assigned at Birth (M/F) _____ Gender Identity* _____ Social Security No. _____

Race/Ethnicity** _____ Date of Birth (MM-DD-YY) _____

Marital Status ☐ Single ☐ Married ☐ Domestic Partnership

Physical Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Mailing Address (if different) _____

City _____ State _____ ZIP _____

Primary Care Provider Name**** _____

Primary Care Provider Address**** _____

Are you a current patient?	☐ Yes	☐ No
Do you use tobacco products?***	☐ Yes	☐ No
Are you enrolled in a tobacco cessation program?	☐ Yes	☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes?	☐ Yes	☐ No

5 Spouse or Domestic Partner (Skip to section 6 if not enrolling a spouse or domestic partner.)

Name (First, MI, Last) _____

Sex Assigned at Birth (M/F) _____ Gender Identity* _____ Social Security No. _____

Race/Ethnicity** _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name**** _____

Primary Care Provider Address**** _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?*** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

6 Dependent Child (Skip to section 7 if not enrolling dependents.)

Name (First, MI, Last) _____

Sex Assigned at Birth (M/F) _____ Gender Identity* _____ Social Security No. _____

Race/Ethnicity** _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name**** _____

Primary Care Provider Address**** _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?*** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child

Name (First, MI, Last) _____

Sex Assigned at Birth (M/F) _____ Gender Identity* _____ Social Security No. _____

Race/Ethnicity** _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name**** _____

Primary Care Provider Address**** _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?*** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Dependent Child

Name (First, MI, Last) _____

Sex Assigned at Birth (M/F) _____ Gender Identity* _____ Social Security No. _____

Race/Ethnicity** _____ Date of Birth (MM-DD-YY) _____

Primary Care Provider Name**** _____

Primary Care Provider Address**** _____

Are you a current patient? ☐ Yes ☐ No
Do you use tobacco products?*** ☐ Yes ☐ No
Are you enrolled in a tobacco cessation program? ☐ Yes ☐ No
Is the tobacco use for Native American or Alaska Native religious or ceremonial purposes? ☐ Yes ☐ No

Attach additional pages if needed ☐ I have attached _____ pages

7 My other insurance information

Please list the most recent health or dental insurance coverage you or any family members listed on this enrollment form have had, including commercial (employer group or individual insurance), Medicaid, Medicare, Medicare Advantage, Medicare supplemental, or Pediatric Dental coverage.

☐ No prior coverage

Name of other insurance company(ies) (include address and phone if available)

_____

Type of Coverage (check all that apply)

☐ Medical ☐ Vision ☐ Pediatric Dental ☐ Adult Dental

Name(s) of individual(s) covered

_____

Date coverage began _____/_____/_____ Date coverage ended _____/_____/_____

Is coverage active? ☐ Yes ☐ No Policy No. _____

If group insurance, name of group _____

8 Certify, authorize, and sign

Be sure to sign and date the enrollment form on this and the following page. Your spouse or domestic partner's signature is also required (if applicable), as is the signature of any child over the age of 18.

Certification of Completeness and Correctness

It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

I affirm that the answers given in this enrollment form are complete and correct and, if this form includes any intentional misrepresentation of material fact or fraud, PacificSource may modify or cancel the contract, and/or take any other legal action available by law. If accepted, coverage will be in force as of the effective date determined by PacificSource. A representative of PacificSource may contact me to clarify answers on this enrollment form.

Representations made by the enrollee are deemed to be representations made on behalf of each person covered under this policy. However, changes to the enrollment form will not be effective until approved in writing by the enrollee. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the enrollee for signature. As the enrollee, I understand I have the right to inspect the information in my file.

Electronic Communications Consent

By checking the "Yes" box at the top of the next page, you are affirming consent to receive secured electronic communications from PacificSource regarding your application and/or enrollment status, changes in insurance coverage, and termination of coverage.

Your consent continues while the plan you enroll in is effective. You may, at any time, opt out of electronic communications by contacting the Customer Service Department at **888-977-9299**. You may request a free paper copy of your application and/or enrollment information by contacting us via email at Individual@PacificSource.com, or by phone at **866-695-8684**. Electronic communications are offered as a convenience only. Your decision to not receive electronic communications will not affect your enrollment. There is no charge associated with switching to paper.

In order to complete the application electronically, you must have a personal computer or other device capable of accessing the internet and the ability to view and revise Portable Document Format (PDF) files.

PacificSource may also send PDF documents to you as part of the application process. You can obtain a free copy of software to view PDF files at http://get.adobe.com/reader/. PacificSource takes the security of electronic information and communications seriously. If you have any questions about our encryption, technical hardware or software, or our security policies and procedures, please contact us at Individual@PacificSource.com.

I agree: ☐ Yes ☐ No Email address _____

I (We) have reviewed and understand the authorization above.

Enrollee/Responsible Party/Guardian Signature _____ Date _____

Printed Name _____ Relationship _____

If enrolling in coverage:

Spouse/Domestic Partner Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Required if enrollee is a minor:

Printed name of ☐ Parent or ☐ Guardian _____

Signature _____ Date _____

This enrollment form must be signed and dated. All fields must be completed for this authorization to be valid. Once accepted, PacificSource will provide the policyholder with a copy of this completed form with the policy.

9 Producer authorization (Skip to section 10 if you are not working with a producer.)

I, the insurance producer, have not made any representations to the enrollee about any provisions, benefits, conditions, or limitations of the policy, except through written material furnished by PacificSource. The enrollee has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the enrollee has been truly and accurately recorded hereon.

Enrollee's Name (printed) _____

Producer's Name (printed) _____

PacificSource Producer Number _____

Producer's Signature _____ Date _____

10 How do you prefer to pay for future premiums?

Your first month's premium must be received by check or money order before your policy will take effect. We will not accept third-party payments except as required by federal law.

Please select your method of payment for future premium payments. Reminder: Your first month's premium can only be paid with a check or money order.

☐ Send me a paper bill by mail each month. *(Skip to section 11.)*

☐ Automatic withdrawal from my bank account, Electronic Funds Transfer (EFT). *The first month's payment cannot be made by EFT.*

We authorize and direct PacificSource Health Plans to withdraw funds as follows:

Amount of monthly withdrawal $_____ Withdrawals will occur on the 5th of each month.

Select one: ☐ Begin transfers on next available date ☐ Delay transfers until _____(Mo.)

Bank information

Bank Name _____

Account No. _____ Routing No. _____

Account type

☐ Checking—attach a voided check ☐ Savings—attach a voided savings withdrawal slip

This authorization will remain in effect until termination by either party. If the individual policy premium changes due to a rate increase, alternate plan selection, or age change of the policyholder, this authorization will automatically be amended to authorize withdrawal of an amount equal to the new premium.

Policyholder's Name (printed) _____ Date _____

Signature of Bank Account Holder _____ Date _____

Important details about the automatic withdrawal of your monthly premiums:

- New accounts may take 30 days to set up. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay by check until the funds transfer is in place.
- Transfers occur on the 5th of each month. If the 5th falls on a weekend or a holiday, the transfer will occur on the next business day.
- Transfers will be made for the premium balance due.
- If EFT is not set up prior to the bill date of the second month, you may receive a paper bill for the second month.

11 Are you ready to submit your application?

☐ Are all sections filled in completely?
☐ Have you attached requested paperwork (guardianship documentation, etc.)?
☐ Did you select a policy coverage date on page 2?
☐ Have you included a check or money order for your first month's premium payment?
☐ Have you selected an ongoing payment option and attached a voided check if needed? (See section 10)

Send your signed, completed enrollment form and attachments to us through any of the following:

Email: Individual@PacificSource.com
Fax: 541-225-3646
Mail: PacificSource Health Plans, PO Box 7068, Springfield, OR 97475-0068

Thank you for enrolling!

PacificSource HEALTH PLANS

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 មូនព័ែ៍មូនយា៉ា ងសំខាន់ ។ បសចកតីជូនំណឹងបនេះ មូនព័ែ៍មូនយា៉ា ងសំខាន់ អុំពីេបួង់ដររេ ឬ ការរ៉ា រ់រង ររស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលររិបចេេសំខាន់ចាំថ់ បៅកនុងបសចកតីជូនំណឹងបនេះ ។ អ្នកប្រដែលជាបុ់េូវការរបចេញសកមមភាព េល់កំណែ់ថ្ងៃជាក់ចាស់នានា បែេើមបីនឹងរកាេុកការរ៉ា រ់រង សុខភាពររស់អ្នក ឬបុ់ាក់ជំនួយបចញថ្ងៃ ។ អ្នកមូនសិេធិេេួលព័ែ៍មូនបនេះ និងជំនួយបៅកនុងភាសាររស់អ្នកបោយមិនអ្ស់លុយបេើយ ។ 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	ການແຈ້ງການນີ້ ມີຂໍ້ມູ ນສໍາຄັ ນ. ການແຈ້ງການນີ້ ມີຂໍ້ມູ ນທີ່ສໍາຄັ ນກ່ ຽວກັ ບຄໍາຮ້ ອງສະໝັ ກຫ ຼືການຄ້ ມ ຄອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ເບິ່ງວັນທີ່ສໍາຄັ ນກ່ ານີ້ ດວ້ ນທ ໍສາຄັ ນໃນແຈ້ງການນີ້ . ທ່ ານອາດຈໍາເປັ ນຕ້ ອງໃຊ້ ເວລາດໍາເນນການໂດຍກໍ ານົ ດເວລາທີ່ແນ່ ນອນ ຈະ ຮັ ກສາການຄ້ ມຄອງສຂະພາບຂອງທ່ ານຫ ຼື ການຊ່ ວຍເຫ ຼື ອທາງຄ່ າໃຊ້ ຈ່ າຍ. ທ່ ານມີສດທຈະໄດ້ ຮັ ບຂໍ້ມູ ນ ຂ່ າວສານນີ້ ແລະການຊ່ ວຍເຫ ຼື ອໃນພາສາຂອງທ່ ານທີ່ບໍ່ມຄ່ າໃຊ້ ຈ່ າຍ. ໂທ (888) 977-9299.
Nepali	यो स चनामा ू महत्त्वप र् ू ू जानकारी छ । यो स चनामा ू तपाईकं ो आवेिन वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विबारे महत्त्वपर्ू ू जानकारी छ । यो सचू नामा भएका महत्त्वपर्ू ू दमदतहरू ख्याल िनुहु ोस् । तपाईलं े पाइरहके ो स्वास््य दबमा पाइरहन वा तपाईकं ो खचुको भक्तानीमा ुसहायता पाउन के ही समयकारवाही िन -सीमामा काम- ुपनेु 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 ਮਹੱਿਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੋ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰੱਿਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿ ੱ 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.