The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to PacificSource.com/plan-details. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at Healthcare.gov/sbc-glossary or call 1-866-556-1224 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network provider: $600 individual/$1,200 family | Out-of-network provider: $10,000 individual/$20,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and other services listed below with 'deductible does not apply'.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at Healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network provider: $6,100 individual/$12,200 family | Out-of-network provider: $25,000 individual/$50,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See providerdirectory.PacificSource.com/Commercial/?nPlan=Navigator or call 1-866-556-1224 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit, deductible does not apply	50% co-insurance	None
	Specialist visit	$40 co-pay/visit, deductible does not apply	50% co-insurance	None
	Preventive care/screening/immunization	No charge, deductible does not apply	50% co-insurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Tobacco cessation: Not covered out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	Diagnostic and therapeutic radiology: $30 co-pay/test, deductible does not apply. Lab services: $20 co-pay/test, deductible does not apply.	50% co-insurance	None
	Imaging (CT/PET scans, MRIs)	$300 co-pay/test	50% co-insurance	Prior authorization required. If not received, you will be responsible for the expense.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PacificSource.com/drug-list	Generic drugs - Tier 1	Retail: $10 co-pay/prescription, deductible does not apply Mail: $20 co-pay/prescription, deductible does not apply	90% co-insurance	For all prescription drug list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, deductible does not apply. Cost share amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail and mail order are limited to a 90 day supply. Quantity for Specialty drug is limited to 30 day supply. Prior authorization required for certain drugs. If not received, you will be responsible for the expense.
	Preferred drugs - Tier 2	Retail: $60 co-pay/prescription, deductible does not apply Mail: $180 co-pay/prescription, deductible does not apply	90% co-insurance	
	Non-preferred drugs - Tier 3	Retail: $100 co-pay/prescription, deductible does not apply	90% co-insurance	

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
		Mail: $300 co-pay/prescription, deductible does not apply		
	Specialty drugs - Tier 4	Retail: $100 co-pay/prescription, deductible does not apply Mail: $300 co-pay/prescription, deductible does not apply	90% co-insurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 co-pay/visit	50% co-insurance	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees	$75 co-pay/visit	50% co-insurance	None
If you need immediate medical attention	Emergency room care	Medical emergency: $450 co-pay/visit Non-emergency: $450 co-pay/visit	Medical emergency: $450 co-pay/visit Non-emergency: 50% co-insurance	Co-pay waived if admitted.
	Emergency medical transportation	Ground: $375 co-pay/trip, deductible does not apply Air: $375 co-pay/trip, deductible does not apply	Ground: $375 co-pay/trip, deductible does not apply Air: $375 co-pay/trip, deductible does not apply	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	$35 co-pay/visit, deductible does not apply	50% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Combined Facility fee and Physician/surgeon fees: $525 co-pay/day, deductible does not apply	50% co-insurance	Co-pay per day, limited to 5 co-pays per stay. Limited to semi-private room, except when a private room is determined to be necessary. Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
	Physician/surgeon fees	Combined Facility fee and Physician/surgeon fees: $525 co-pay/day, deductible does not apply	50% co-insurance	None

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $15 co-pay/visit, deductible does not apply Other outpatient care: $15 co-pay/visit, deductible does not apply.	50% co-insurance	None
	Inpatient services	$525 co-pay/day, deductible does not apply	50% co-insurance	Co-pay per day, limited to 5 co-pays per stay. Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
If you are pregnant	Office visits	Included in childbirth/delivery facility services	Included in childbirth/delivery facility services	Hospital/Facility services: Co-pay per day, limited to 5 co-pays per stay. Cost sharing does not apply for preventive services. Delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services.
	Childbirth/delivery professional services	Included in childbirth/delivery facility services	Included in childbirth/delivery facility services	
	Childbirth/delivery facility services	$525 co-pay/day, deductible does not apply	50% co-insurance	
If you need help recovering or have other special health needs	Home health care	$15 co-pay/visit	50% co-insurance	Limited to 130 visits/year. No coverage for private duty nursing or custodial care.
	Rehabilitation services	Inpatient: $525 co-pay/day, deductible does not apply Outpatient: $25 co-pay/visit, deductible does not apply	Inpatient: 50% co-insurance Outpatient: 50% co-insurance	Inpatient: Co-pay per day, limited to 5 co-pays per stay. Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	Habilitation services	Inpatient: $525 co-pay/day, deductible does not apply Outpatient: $25 co-pay/visit, deductible does not apply	Inpatient: 50% co-insurance Outpatient: 50% co-insurance	Inpatient: Co-pay per day, limited to 5 co-pays per stay. Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care	$350 co-pay/day	50% co-insurance	Co-pay per day. Limited to 60 days/year. No coverage for custodial care.
	Durable medical equipment	20% co-insurance	50% co-insurance	Limited to: one pair/year for glasses or contact lenses; one manual or electric breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Prior authorization required in certain

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
				circumstances, if not received, you will be responsible for the expense.
	Hospice services	$15 co-pay/visit	50% co-insurance	No coverage for private duty nursing. Respite care limited to 14 days lifetime.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	No charge up to $40 maximum, deductible does not apply, then 100% co-insurance	For age 18 or younger, two routine eye exams/year.
	Children's glasses	No charge, deductible does not apply	No charge up to $40 maximum, deductible does not apply, then 100% co-insurance	For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year.
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery (except in certain situations)
- Dental care (Adult)
- Hearing aids (Adult)
- Hearing aids (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture - 12 visits/year
- Chiropractic care - 12 visits/year
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Office of the Insurance Commissioner at 1-800-562-6900 or at insurance.wa.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit Healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete

information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The PacificSource Customer Service team at 1-866-556-1224 or the Office of the Insurance Commissioner at 1-800-562-6900 or at insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.
If your plan doesn't meet the Minimum Value Standards you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-556-1224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-556-1224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-556-1224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $600
- **Specialist** $40 co-payment
- **Hospital (facility)** $525 co-payment
- **Other** 20% co-insurance

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests *(ultrasounds and blood work)*

Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $600
- **Specialist** $40 co-payment
- **Hospital (facility)** $525 co-payment
- **Other** 20% co-insurance

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*

Diagnostic tests *(blood work)*

Prescription drugs

Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$1200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,860**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $600
- **Specialist** $40 co-payment
- **Hospital (facility)** $525 co-payment
- **Other** 20% co-insurance

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*

Diagnostic test *(x-ray)*

Durable medical equipment *(crutches)*

Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

PacificSource HEALTH PLANS

Discrimination Is Against the Law

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

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, sex, gender identity or sexual identity, 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 your 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

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241(TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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 من دون أي تكلفة. اتصل بـ (888) 977-9299
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 មួនព័ែ៍មួនយា៉ា ងសំខាន់ ។ បសចកតីជូនំណឹងបនេះ មួនព័ែ៍មួនយា៉ា ងសំខាន់ អ្ំពីេប្ចង់ដររេ ឬ ការរ៉ា ររង ររស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដសែងរកកាលររិបចេេសំខាន់ចាំច់ បៅកនុងបសចកតីជូនំណឹងបនេះ ។ អ្នកប្រដែលជាប់ែ្វការរបចេញសកមមភាព ែល់កំណែំថ្ងៃជាក់ចាស់នានា បែេើមបីនឹងរកាេុកការរ៉ា ររង សុខភាពររស់អ្នក ឬប្ាក់ជំនួយបចញថ្ងៃ ។ អ្នកមួនសិេធិេេួលព័ែ៍មួនបនេះ និងជំនួយបៅកនុងភាសាររស់អ្នកបោយមិនអ្ស់លុយប េើយ ។ សូមេ្ូរស័ពទ (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	ການແຈ້ງການນັ ມ່ຂໍ້ ມູ ນ່ສາຄັ ນ. ການແຈ້ງການນັ ມ່ຂໍ້ ມູ ນ່ທໍ່ສາຄັ ນກ່ ຽວກັ ບ່ຄາຮ້ ອງສະໝັ ກຫ ູ ື ການຄ້ ມ ຄອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ເ່ິ່ບງໍ່ສາລັ ບກໍ່ ານົ ດວັ ນ່ທ ໍ່ສາຄັ ນໃນແຈ້ງການນັ . ທ່ ານອາດໍ່ຈາເປັ ນຕ້ ອງໃຊ້ ເວລາໍ່ດາເນນການໂດຍກໍ່ ານົ ດເວລາໍ່ທແນ່ ນອນ ຈະ ຮັ ກສາການຄ້ ມຄອງສຂະພາບຂອງທ່ ານຫ ູ ື ການຊ່ ວຍເຫ ູ ື ອ່ທມຄ່ າໃຊ້ ຈ່ າຍ. ທ່ ານມິສດ່ທຈະໄດ້ ຮັ ບ່ຂໍ້ ມູ ນ ຂ່ າວສານນັ ແລະການຊ່ ວຍເຫ ູ ື ອໃນພາສາຂອງທ່ ານ່ທໍ່ບມຄ່ າໃຊ້ ຈ່ າຍ. ໂທ (888) 977-9299.
Nepali	यो स चनामा ू महत्त्वप र्ू ू जानकारी छ । यो स चनामा ू तपाईकं ो आवेि न वा PacificSource Health Plans का माध्यमबाटप्राप्त हुने सदु विबारे महत्त्वपर्ू ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्ू ु दमदतहरू ख्याल िनुहु ोस् । तपाईलं े पाइरहके ो स्वास्् य 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 शल् ु 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 (888) 977-9299 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 ਕੁ ਿ ੱ ਝ ਖਾਸ ਕਦਮ ਚੁ ਿ ੱ 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.