Individual and Family Policy Enrollment Form—Dental Only Idaho

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 (if you're not filling it out electronically).
- 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 broker's information, if applicable.
- Your first month's premium payment (required before your policy will take effect).

You are eligible to enroll if:

- You are a resident of the state of Idaho, you do not have residency status in any other state, and can provide satisfactory proof of current Idaho residency. An individual who intends to reside in Idaho may submit an application for insurance but would not be eligible to begin coverage prior to the individual physically residing in Idaho.
- Your spouse/domestic partner (if applicable) is your legal spouse/domestic partner.
- Your children (if applicable) are your natural or adopted children, under age 26, or you are their legal guardian.

Need help?

If you have questions about any part of this enrollment form, we'd be happy to help. You can reach a PacificSource Coverage Advisor at **855-330-2792,** TTY: **711.** We accept all relay calls.

What happens after you submit your application

We'll begin processing your application, and in the coming weeks, you'll receive a few things from us. To get information faster, include your email address in your application.

1. Look for your ID cards in the mail close to the date your plan begins.
2. We'll also mail your full policy.

Please keep a copy of this application for your records.

If you would like to enroll in a PacificSource Individual or Family medical policy, visit the "Shop Plans" page at Shop.PacificSource.com/Individual. Need help? Contact a PacificSource Coverage Advisor at **855-330-2792.**

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)
- ☐ Change my plan as shown below

2 Choose a plan

- ☐ Dental PPO 0-20-50 1000
- ☐ Dental PPO 0-20-50 1500
- ☐ Kids Dental PPO 0-20-50 (coverage for members 18 and younger)

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

3 Select a coverage date

What date would you like the coverage to begin? ☐ 1st or ☐ 15th of ____/_____ Mo/Yr.

Enrolling myself and my family

List all family members you would like insured. Only your legal spouse, domestic partner, and dependent children are eligible.

*__Gender identity__ (optional): **NB**-Non-binary, **TM**-Trans man, **TW**-Trans woman

__Race/ethnicity__ (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

ICHRA Eligible

Are you enrolling under an ICHRA sponsored plan? ☐ Yes ☐ No

If applicable, please provide the name of your ICHRA Administrator _____

4 Applicant or Parent/Guardian (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 _____

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) ______________________

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) ______________________

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) ______________________

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) ______________________

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) ______________________

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) ______________________

Attach additional pages if needed ☐ I have attached _____ pages

7 My other insurance information

Do you, or any people listed on this enrollment form, have other dental insurance coverage, including commercial (employer group or individual dental insurance), or Medicare Advantage coverage? ☐ Yes ☐ No (If no other coverage, skip to section 8.)

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

_____ Policy No. _____

_____ Policy No. _____

_____ Policy No. _____

Name(s) of individual(s) covered

_____ Is coverage active? ☐ Yes ☐ No

If group insurance, name of group _____

Date coverage began _____/_____/_____ Is this coverage terminating? ☐ Yes ☐ No

If Yes, what is the coverage end date? _____/_____/_____

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
I affirm that the answers given in this enrollment form are complete and correct. I am providing these answers as part of the enrollment form procedure required by PacificSource to enroll in its insurance coverage. I understand that if this enrollment form contains 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. I will promptly inform PacificSource in writing if anything happens before my coverage takes effect that makes the information I have provided on this enrollment form incomplete or incorrect. I understand and agree that no coverage will be in force until accepted by PacificSource. 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 applicant 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 applicant. An enrollment form received by PacificSource requiring alterations will be modified by amendment and sent to the applicant for a signature. As the applicant, I understand I have the right to inspect the information in my file.

Electronic Communications Consent
By checking the "Yes" box on 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, termination of coverage, and plan and benefit information.

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 **800-591-6579.** 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 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 to receive emails: ☐ Yes ☐ No Email address _____

I agree to receive texts: ☐ Yes ☐ No Mobile phone number _____

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

Applicant or Parent/Guardian:

Printed name of ☐ Parent ☐ Guardian ☐ Applicant _____

Signature _____ Date _____

If enrolling in coverage:

Spouse/Domestic Partner Signature _____ Date _____

Child age 18 or older Signature _____ Date _____

Child age 18 or older 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 upon request. The policy provides dental benefits only. Review your policy carefully.

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 applicant about any provisions, benefits, conditions, or limitations of the policy except through written material furnished by PacificSource. The applicant has been informed that the effective date of coverage is assigned only by PacificSource. I hereby certify that information supplied to me by the applicant has been truly and accurately recorded hereon.

Applicant's Name (printed) _____

Producer's Name (printed) _____

PacificSource Producer No. _____

Producer's Signature _____ Date _____

10 How do you prefer to pay for future premiums?

Your first month's premium must be received by paying online at InTouch.PacificSource.com/OneTimePayment or by mailing us a check. This policy will not be in effect until the initial payment is received. *We will not accept third-party payments except as required by federal law.*

Please select your method of payment for future premium payments.

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

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

I/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, this authorization will automatically be adjusted to authorize withdrawal of an amount equal to the new premium.

Applicant or parent/guardian's name (printed) _____ Date _____

Signature of bank account holder _____ Date _____

Important details about the automatic withdrawal of your monthly premiums:

- Initial setup takes up to 30 days. If your policy is accepted and coverage starts sooner than your automatic withdrawal is set up, you may need to pay online or 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?

☐ Are all sections filled in completely?

☐ Have you attached requested paperwork (e.g., guardianship documentation, etc.)?

☐ Did you select a policy coverage date on page 2?

☐ Have you included your first month's premium payment (required before your policy will take effect)?

☐ 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 by:

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

Thank you for enrolling!

Discrimination is against the law

PacificSource Health Plans and PacificSource Community Health Plans ("PacificSource") complies with applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act. PacificSource does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)), age or disability. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

Language assistance services

PacificSource will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:

- Electronic and written translated documents
- Qualified interpreters
- Appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication

Appropriate auxiliary aids and services may include:

- Qualified interpreters, including American Sign Language interpreters
- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)

Reasonable modifications

PacificSource will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

To access our language assistance services, auxiliary aids and services, and for assistance in getting a reasonable modification, please contact Customer Service at **888-977-9299,** TTY: 711. We accept all relay calls.

Continued >

Contact our commercial Customer Service team:

Phone
Toll-free: 888-977-9299
TTY: 711
We accept all relay calls.

Email
CS@PacificSource.com

PacificSource.com

Contact our Medicare Customer Service team:

Oct. 1 – Mar. 31:
8:00 a.m. – 8:00 p.m.,
seven days a week

Apr. 1 – Sept. 30:
8:00 a.m. – 5:00 p.m.,
Monday – Friday

Phone
Toll-free: 888-863-3637
TTY: 711
We accept all relay calls.
En Español: 866-281-1464

Email
MedicareCS
@PacificSource.com

Medicare.PacificSource.com

PacificSource

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 PacificSource's Section 1557 Coordinator.

Phone: **888-977-9299,** TTY: 711. We accept all relay calls.

Email: 1557Coordinator@PacificSource.com

Mail: PacificSource
PO Box 7068
Springfield, OR 97475

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Electronically: OCRPortal.hhs.gov

Mail: U.S. Department of Health & Human Services
200 Independence Avenue, S.W., Room 509F
Washington, D.C. 20201

Notice of availability of language assistance services and auxiliary aids and services

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-431-4135 (TTY: 800-735-2900) or speak to your provider.
አማርኛ Amharic	ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 800-431-4135 (TTY: 800-735-2900) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-431-4135 (800-735-2900) أو تحدث إلى مقدم الخدمة
Bantu-Kirundi	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 800-431-4135 (TTY: 800-735-2900).
ភាសាខ្មែរ Cambodian Non-Khmer	សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 800-431-4135 (TTY: 800-735-2900) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
中文 Simplified Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-431-4135（文本电话：800-735-2900）或咨询您的服务提供商。
中文 Traditional Chinese	注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 800-431-4135（TTY：800-735-2900）或與您的提供者討論。

Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-431-4135 (TTY: 800-735-2900).
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-431-4135 (TTY: 800-735-2900) an oder sprechen Sie mit Ihrem Provider.
فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 800-431-4135 (تلەتایپ: 800-735-2900) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Français French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-431-4135 (ATS : 800-735-2900).
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-431-4135 (TTY: 800-735-2900).
日本語 Japanese	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-431-4135（TTY：800-735-2900）までお電話ください。または、ご利用の事業者にご相談ください。
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-431-4135 (TTY: 800-735-2900) 번으로 전화하거나 서비스 제공업체에 문의하십시오.
ລາວ Laotian	ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-431-4135 (TTY: 800-735-2900) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Nepali	ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्तिि भाषा सहायता सेवाहरू नशिुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800-431-4135 (टटिीवाइ: 800-735-2900) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 800-431-4135 (TTY: 800-735-2900).
Pennsylvania Dutch	Wann du Deitsch (Pennsylvania German/Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800-431-4135 (TTY: 800-735-2900).
ਪੰਜਾਬੀ Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 800-431-4135 (TTY: 800-735-2900) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135 (TTY: 800-735-2900).

РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-431-4135 (TTY: 800-735-2900) или обратитесь к своему поставщику услуг.
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-431-4135 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 800-735-2900).
Soomaali Somali	FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 800-431-4135 (TTY: 800-735-2900) ama la hadal bixiyahaaga.
Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-431-4135 (TTY: 800-735-2900) o hable con su proveedor.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-431-4135 (TTY: 800-735-2900) o makipag-usap sa iyong provider.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135 (TTY: 800-735-2900).
українська мова Ukrainian	УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 800-431-4135 (TTY: 800-735-2900) або зверніться до свого постачальника.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-431-4135 (Người khuyết tật: 800-735-2900) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Idaho dental plans for individuals and families
Sample general limitations and exclusions

PacificSource HEALTH PLANS

As with any insurance plan, there are some services and treatments that have coverage limits or are not covered at all. For example, experimental procedures are typically not covered. This document outlines what's not covered by your dental plan.

Please note: A full explanation of benefits, including limitations and exclusions, will be provided in your policy. Only the language of the actual policy is legally binding.

This policy does not provide benefits in any of the following circumstances or for any of the following conditions.

- Aesthetic (cosmetic) dental procedures – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- Alveolectomy when performed in conjunction with tooth extraction – Separate charge not covered for Members age 19 and older.
- Anesthesia when performed in conjunction with a restorative procedure – Separate charge not covered for Members age 19 and older.
- Antimicrobial agents – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- Athletic injuries sustained while competing or practicing for a professional athletic contest.
- Athletic mouth guards for Members age 19 and older.
- Biopsies or histopathologic exams – A separate charge for a biopsy of oral tissue or histopathologic exam.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims.
- Collection of cultures and specimens for Members age 19 and older.
- Connector bar or stress breaker.
- Core build-ups unless used to restore a tooth that has been treated endodontically (root canal) for Members age 19 and older.
- Cosmetic reconstructive services and supplies – Procedures, appliances, Restorations, or other services that are primarily for cosmetic purposes. (Congenital Anomalies are not considered cosmetic.)
- Denture replacement due to loss, theft, or breakage, unless otherwise noted in Covered Services.
- Diagnostic casts (study models) for Members age 19 and older.Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a Provider for any Member, as well as premedication drugs, analgesics, and any other euphoric drugs for Members age 19 and older.
- Drugs and medications that are prescribed drugs and take-home medicine or supplies distributed by a Provider for any Member. As well as premedication drugs, analgesics, and any other euphoric drugs for Members age 19 and older.
- Educational programs – Plaque control programs, oral hygiene instruction, and dietary instructions.
- Experimental, Investigational, or Unproven – This policy does not cover services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. This limitation also excludes treatment that, when and for the purpose rendered: has not yet received recognized compendia support (for example, UpToDate, Lexicomp, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing; is not of generally accepted medical practice in your policy's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

  If you or your Provider have any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service team. We will arrange for medical review of your case against our criteria, and notify you of whether or not the proposed treatment will be covered.
- Fractures of the maxilla and mandible – Surgery, services, and supplies provided in connection with the treatment of simple or compound fractures of the maxilla or mandible.
- General anesthesia except when administered by a Provider in connection with oral surgery in their office, unless otherwise noted in Covered Services.
- Gingivectomy, gingivoplasty, or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service.
- Gnathological recordings, occlusal equilibration procedures, or similar procedures.
- Hospital charges or additional fees charged by the Provider for hospital treatment for Members age 19 and older.
- Hypnotherapy.
- Indirect pulp caps are to be included in the Restoration process, and are not a separate Covered Service.
- Infection control – A separate charge for infection control or sterilization.

- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- Mail order or Internet/web-based Providers are not eligible Providers.
- Orthodontic services – Repair or replacement of orthodontic appliances.
- Orthodontic services – Treatment of misalignment of teeth and/or jaws, or any ancillary services performed because of orthodontic treatment, except as specified in the Covered Services section.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw.
- Periodontal probing, charting, and re-evaluations.
- Photographic images.
- Pin retention in addition to Restoration for Members age 19 and older.
- Precision attachments.
- Pulpotomies on permanent teeth for Members age 19 and older.
- Removal of clinically serviceable Amalgam Restorations to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- Services covered by the Member's medical policy.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services for which no charge is normally made in the absence of insurance.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies covered under any policy or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies with no charge, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any services provided by the Member, or any licensed professional that is an Immediate Family Member.
- Services, supplies, and medications outside of the United States.
- Sinus lift grafts to prepare sinus site for implants.
- Stress-breaking or habit-breaking appliances.
- Temporomandibular joint (TMJ) – Services or supplies for treatment of any disturbance of the temporomandibular joint.
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation – Any services or supplies for Illness or Injury for which a third party is responsible or which are payable by such third party or which are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, and Personal Injury Protection (PIP) insurance and any other liability and voluntary medical payment insurance to the extent of any recovery received from or on behalf of such sources.
- Tooth transplantation – Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the reimplantation of a tooth into its original socket after it has been avulsed.
- Treatment after insurance ends – Services or supplies a Member receives after the Member's coverage under this policy ends. The only exception is for Class III Services ordered and fitted before enrollment ends and are placed within 31 days after enrollment ends.
- Treatment not Dentally Necessary, according to acceptable dental practice, or treatment not likely to have a reasonably favorable prognosis.
- Treatment of any Illness or Injury arising out of an illegal act or occupation or participation in a felony.
- Treatment prior to enrollment or satisfaction of an Exclusion Period, if applicable.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release dental or eligibility information necessary to determine the benefits covered under this policy.
- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or while in the service of the armed forces unless not covered by the Member's military or veterans coverage.

Renewability of individual policy

This policy is guaranteed renewable with respect to all Members at the option of the Policyholder, except in the following cases:

- For nonpayment of the required premium. Notice of cancellation for nonpayment of premiums will be mailed within 15 days after the due date of the missed premium for that period;
- For fraud or the intentional misrepresentation of a material fact by the Policyholder;
- When PacificSource discontinues offering or renewing all of its individual stand-alone dental policies within the state of issuance or in a specific area within the state. Discontinuation of all individual stand-alone dental policies are subject to notification at least 180 days in advance of discontinuation of the policies;
- When PacificSource discontinues offering or renewing this policy in a specified area within the state of issuance because of an inability to reach an agreement with the Providers or organization of Providers to provide services under the policy within the service area. Discontinuation of this policy is subject to notification at least 90 days in advance of discontinuation of the policy;
- If the Department of Insurance finds that renewal would not be in the interest of the Member, or would impair PacificSource's ability to meet its contractual obligations;
- When the Member no longer lives or resides in the state of issuance or counties in which the product is offered; or
- When the Policyholder terminates the policy on any premium due date with 15 days prior written notice.

Disclosure of premium practices and guarantees

a) How Premiums Are Set
Your premium is determined by the benefits you selected, your geographic location, and the age of the individuals covered on your policy. Any renewal premium increase is due to changes in age and any increase approved by the Department of Insurance.

b) Premium Guarantee
We guarantee initial premium until your next renewal date. Your premium may change if you change your benefits at renewal.