

# Individual and Family Policy Enrollment Form—Dental Only Idaho



## Thank you for choosing PacificSource!

You may also enroll online at [PacificSource.com](https://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.

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### 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](http://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

### Change to My Current Coverage

- Or** 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

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): **A**-Agender, **GF**-Gender fluid, **GN**-Gender nonconforming, **GO**-Genderqueer, **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** (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

## 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](mailto: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](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](mailto: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](http://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](mailto: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 (“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](mailto: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>

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

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	បសចកតិដូនៃន័ណឹងបនេះ ម្តងពីរ័ម្តងយ៉ាងសំខាន់ ។ បសចកតិដូនៃន័ណឹងបនេះ ម្តងពីរ័ម្តងយ៉ាងសំខាន់ អុំពីរ័ប្រដំដររ ឬ ការរាំ រង រស់អ្នកតាមរយៈ PacificSource Health Plans។ សូមដលែងរកកាលរិបចេសំខាន់ចាំចំ បៅកនុងបសចកតិដូនៃន័ណឹងបនេះ ។ អ្នកប្រដែលជាបុរ័រការរបចេញសកមមភាព រ័លកំណែថ្ងៃជាកំចាស់នានា បរ័មបីនឹងរការុកការរាំ រង សុខភាពរស់អ្នក ឬបុរ័កំជំនួយបចេញថ្ងៃ ។ អ្នកម្តងសិរ័ធិរ័ង្កលពីរ័ម្តងបនេះ នឹងជំនួយបៅកនុងភាសារស់អ្នកបោយមិនអ្សលុយបរ័យ ។ សូមរ័រស័ពទ (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	<p>본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 PacificSource Health Plans 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.</p> <p>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.</p>
Laotian	<p>ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນ. ການແຈ້ງການນີ້ ມີຂໍ້ ມູ ນໍ້ສາຄໍ ນກໍ່ ງອກ ບໍ່ຄາຍ້ ອງສະໜັ ກຫ ັ້ ການຄໍ ມ ອອງຂອງທ່ ານໂດຍຜ່ ານ PacificSource Health Plans. ຕື່ ບ່ງສາຄໍ ບກໍ່ ານ ດວ້ ນທ ັ້ ສາຄໍ ນໃນແຈ້ ງການນີ້ . ທ່ ານອາດຈາເບ້ ນຕໍ່ ອງໃຊ້ ເວລາດາເນນການໂດຍກໍ່ ານ ດເວລາທ່ ານ ນອນ ຈະ ຮໍ ກສາການຄໍ ມອອງສຂະພາບຂອງທ່ ານຫ ັ້ ການຊໍ ວຍເຫ ັ້ ອໍ່ທມຄໍ່ າໃຊ້ ຈໍ່ າຍ. ທ່ ານມັສດທຈະໄດ້ ຮໍ ບໍ່ຂໍ້ ມູ ນ ຂໍ່ າວສານນີ້ ແລະການຊໍ ວຍເຫ ັ້ ອໃນພາສາຂອງທ່ ານທໍ່ ບມຄໍ່ າໃຊ້ ຈໍ່ າຍ. ໂທ (888) 977-9299.</p>
Nepali	<p>यो स चनामाा महत्त्वप र्ु जानकारी छ । यो स चनामाा तपाईंको ो आवेिन वा PacificSource Health Plans का माध्यमबाट प्राप्त हुने सद्ु विबारे महत्त्वपर्ु जानकारी छ । यो सचू नामा भएका महत्त्वपर्ु दमदतहरू ख्याल िनुहु ोस् । तपाईंले पाइरहके ो स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भक्तानीमाुसहायता पाउन के ही समयकारवाही िन -सीमामा काम-ुपनु हनसक्छु । तपाईंले यो जानकारी र सहायता आफ्नो मातभू ाषामा दन शलु क पाउनु तपाईंको अदिकारः हो (888) 977-9299 मा फोन िनुहु ोस् ।</p>
Norwegian	<p>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.</p>
Pennsylvania Dutch	<p>Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung 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 beschtimnde Deadlines, so ass du dei Health Coverage bhalde kansch, odder bezaahle helfe kansch. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kansch du (888) 977-9299 uffrufe</p>
Persian	<p>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</p>
Punjabi	<p>ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੇ ਜਿਸ ਜਵਚ PacificSource Health Plans ਵਲੋਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਿਾਰੇ ਮਹਿੰ ਤਵਪ ਰਨ ਜਾਣਕਾਰੀ ਹੈ . ਇਸ ਨੇ ਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਲਈ ਵੇਖੋ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱ ਚ ਮਦਦ ਦੇ ਇਛੁਿੱ ਕ ਹੋ ਤਾਂ ਤੁਹਾਨ ੂੰ ਆ ਤਮ ਤਾਜਰਖ ਤੋ ਪਜਹਲਾਂ ਕੁਿੱ ਝ ਖਾਸ ਕਦਮ ਚੁਿੱ ਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ. ਤੁਹਾਨ ੂੰ ਮੁਫਤ ਜਵਚ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਜਵਿੱ ਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ. ਕਾਲ (888) 977-9299</p>
Romanian	<p>Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră 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.</p>

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию 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 određene 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	ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอเขตประกันสุขภาพของคุณผ่าน PacificSource Health Plans ดูกำหนดการในประกาศนี้คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโทร (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страховального 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.

# Idaho dental plans for individuals and families

## Sample general limitations and exclusions



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.
  - Cast Restorations for partial denture Abutment teeth or for splinting purposes unless the tooth in and of itself requires a Cast Restoration.
  - 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 adjustment or relines performed within six months of the initial placement.
  - 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.
  - Educational programs – Instructions and/or training in plaque control and oral hygiene for Members age 19 and older.
  - 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.
- Scheduled and/or non-emergent care outside of the United States.
- 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 directly related to the Member by blood or marriage.
- 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 re-implantation from one site to another, splinting, and/or stabilization. This exclusion does not relate to the re-implantation 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.