



# Beyond what's required

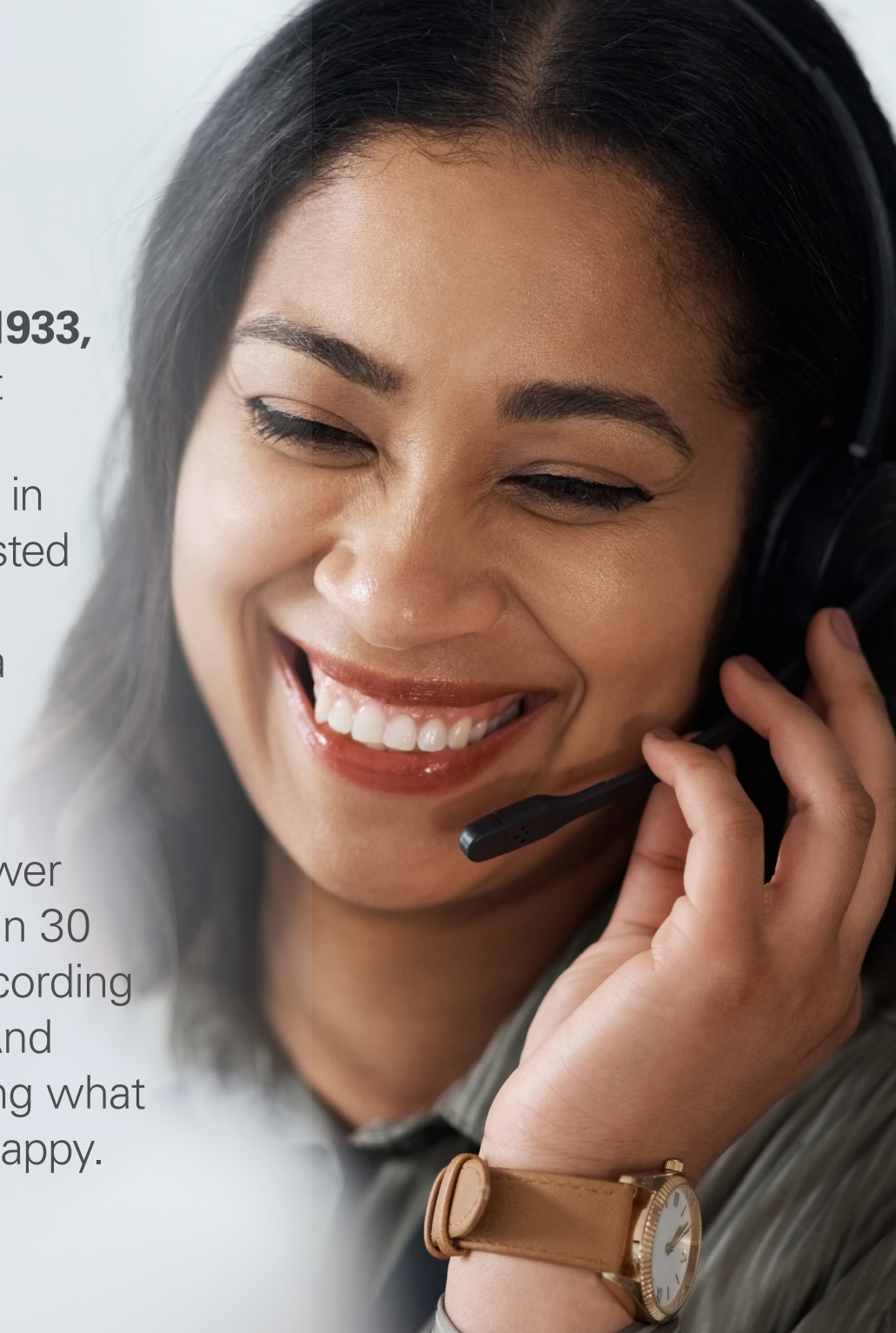
2023 Health Plans for **Idaho Small Groups** | 2–50



# Here to **help**

**Since our founding in 1933,** we've learned a lot about keeping members and employers satisfied. Year in and year out, we've invested in the relationships and technologies that mean a better experience for all.

Our staff is right here in the Northwest. We answer member calls in less than 30 seconds on average, according to internal call reports. And we're committed to doing what it takes to keep clients happy.



PacificSource is a **not-for-profit community health plan**. We don't answer to shareholders, but to members, providers, producers, and employers—the people who depend on our products and services.

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# Health plans that focus on the right things: **members, providers,** and **communities**



## A unique, not-for-profit partnership

PacificSource is different. We're a local health insurer that works closely with highly rated providers to deliver exceptional member experience.



## Integrated care that revolves around members

This patient-centered approach is enabled by close collaboration with our provider partners, supported by best-in-class data analytics.



## High-value care and lower costs

We strive to compensate providers fairly, based on quality of outcomes and overall value—not volume.



## Ongoing investment in community health

As a not-for-profit insurer, PacificSource continually invests in our own neighborhoods, through financial aid and access to healthcare for diverse populations and those most in need.

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**98%**

That's our average employer satisfaction rating, based on surveys conducted March 2021 – February 2022. The remaining 2%? We're working on it.

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# Benefits that go beyond what's required



## Expanded telehealth coverage

Members can see a doctor without leaving home. Your employees get the care they need, where and when they need it.



## No referrals required with any plan

Our plans don't require members to visit a primary care doctor before seeing a specialist. (Some specialists may have their own referral requirements.)



## No-cost preventive care and preventive drugs

We're pleased to offer \$0 copays on:

- Well-baby and well-child care
- Annual checkups
- Prenatal consultations
- Preventive mammograms and colonoscopies
- Immunizations
- Dozens of preventive drugs—including 82 more than the law requires



## Human service

No automated phone trees or offshore call centers.















## Client service that puts you first

You'll have a dedicated representative who's focused on you, your plan details, and helping you control costs.

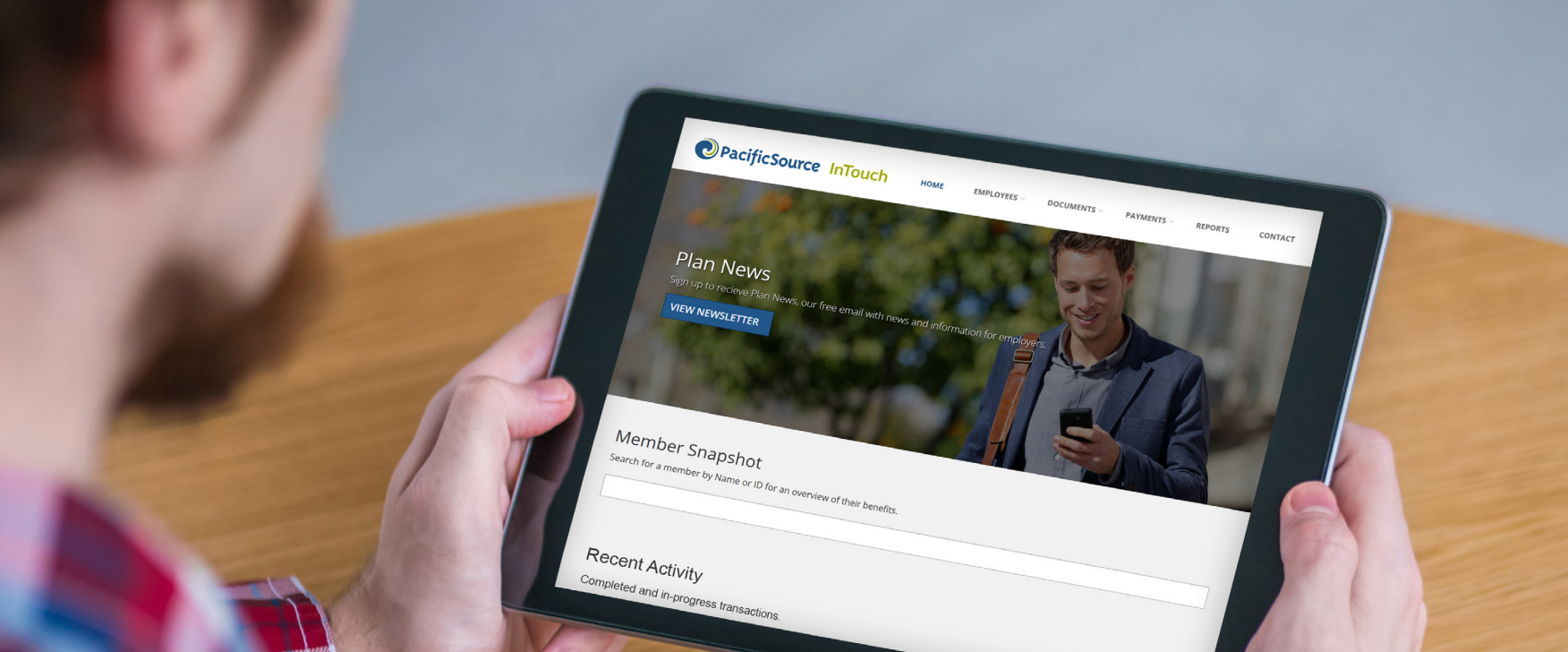
PacificSource Health Plans covers more than **234,000** members and their families in the Greater Northwest.

Our business clients include companies working in a variety of industries.  
That's experience we can leverage to help you.

			
Manufacturing	Construction	Education	Legal
			
Wholesale Supply	Medical	Retail	Restaurants
			
Banking	Agriculture	Nonprofit	Transportation

Source: monthly enrollment report, March 2022





# InTouch puts you in charge



**Manage employee benefits from your computer, phone, or tablet, 24/7.**

**You'll have employer-only access to all your insurance information through our secure online portal.**

## **With InTouch for Employers you can:**

### **Easily pay your bill**

View statements, pay online, and review payment history.

### **Run reports**

Know who and how many employees are covered.

### **Get info on demand**

See benefit summaries, your contract, handbooks, and more.

### **Manage enrollment status**

Easily add, update, and delete employee information.

### **ID cards**

Request ID cards and print temporary ones.

### **Keep in touch**

Easy-to-find contact information for your PacificSource representatives.



## The Navigator **difference**

### **A coordinated network of highly rated medical professionals**

Your provider network determines which doctors and hospitals are covered at the highest benefit level.

In Idaho, the Navigator network includes **St. Luke's Health Partners, Patient Quality Alliance, Eastern Idaho Regional Medical Center, and Bingham Memorial Hospital.** Plus thousands of independent practitioners, including acupuncture, chiropractic, and naturopathic care providers.

Navigator also offers out-of-network benefits, for greater freedom and choice.

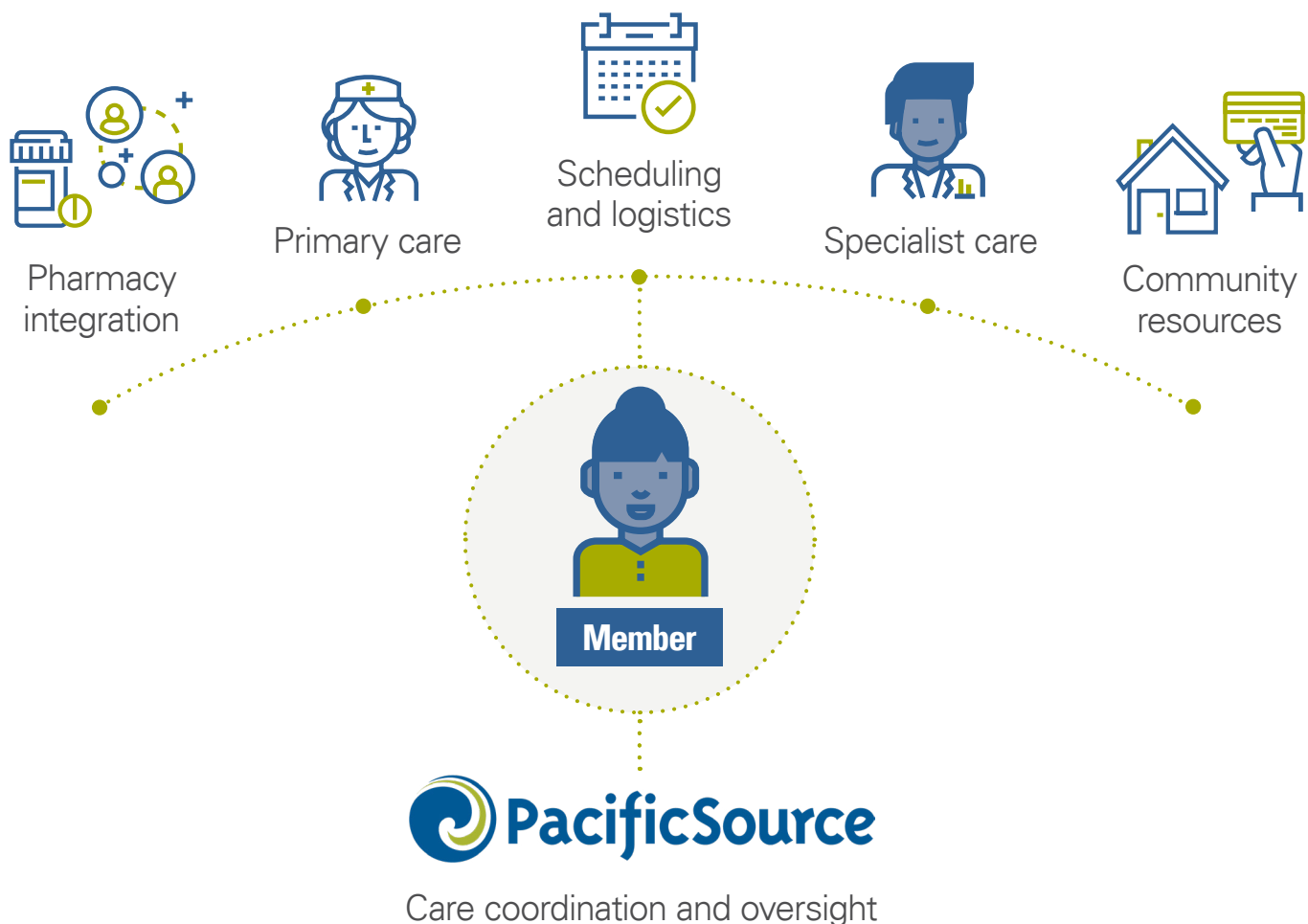
# Navigator

## Cost-effective care coordination that puts members at the center

Navigator products are designed to support member engagement and promote shared decision making with providers.

With Navigator, members have access to a broad array of in-network healthcare providers—locally, within our four-state service area, and nationally (see page 10). Out-of-network benefits are included as well.

**Employees experience seamless, accountable care** from a dedicated team of providers.





## Give your staff **the doctors and hospitals they want.**

We've partnered with well-respected health centers and hospitals in the region to provide members and their families with quality care.

### Idaho

Blackfoot  
Boise  
Idaho Falls  
Nampa/Caldwell  
Pocatello  
Twin Falls

**St. Luke's**  
**HealthPartners**

**PQA**  
Patient Quality Alliance

**EIRMC**  
EASTERN IDAHO  
REGIONAL MEDICAL CENTER

**BINGHAM MEMORIAL HOSPITAL**  
*Experience Bingham!*

**U HEALTH**  
UNIVERSITY OF UTAH

### Montana

Statewide

**Billings Clinic**

**PROVIDENCE**  
St. Patrick Hospital

**COMMUNITY**  
MEDICAL CENTER

**St. Peter's Health**

**SCL Health**

**LOGAN**  
HEALTH

### Oregon

Statewide

**LEGACY**  
HEALTH

**CENTRAL OREGON**  
INDEPENDENT PRACTICE ASSOCIATION

**OHSU**  
Health

**PeaceHealth**

**LEGACY**  
HEALTH PARTNERS

**McKenzie-Willamette**  
MEDICAL CENTER

**ASANTE**

**St. Charles**  
HEALTH SYSTEM

### Washington

Spokane  
Tacoma  
Vancouver

**MultiCare**

**MultiCare**  
Connected Care™

**LEGACY**  
HEALTH

**VANCOUVER CLINIC**

In-network availability is based on member's plan and network.

## How Navigator **benefits employers**



Multiple plan designs



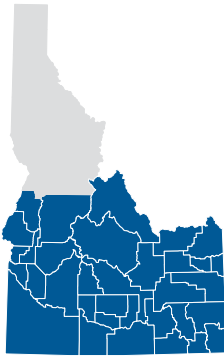
Controlled costs



Clinical integration



Unified communications

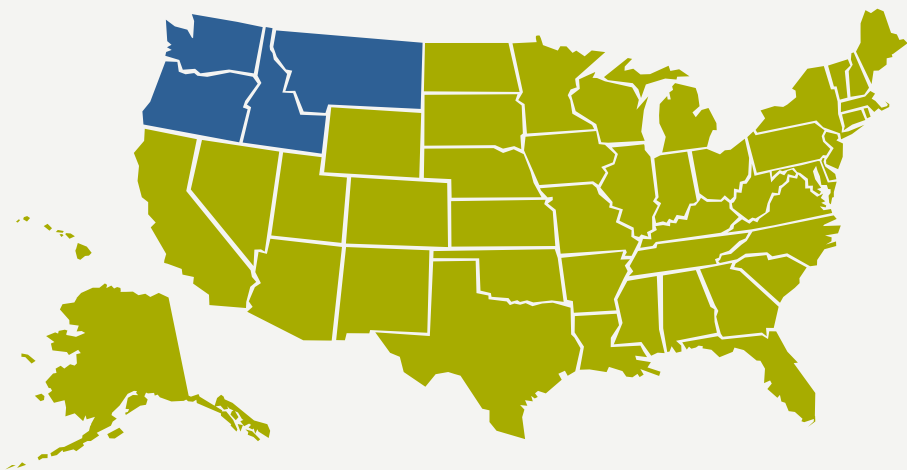


### **Navigator is available for purchase by businesses**

**located in the following counties:** Ada, Adams, Bannock, Bear Lake, Bingham, Blaine, Boise, Bonneville, Butte, Camas, Canyon, Caribou, Cassia, Clark, Custer, Elmore, Franklin, Fremont, Gem, Gooding, Jefferson, Jerome, Lemhi, Lincoln, Madison, Minidoka, Oneida, Owyhee, Payette, Power, Teton, Twin Falls, Valley, and Washington



# In-network, **nationwide**



- Our four-state provider network
- First Health®** and **First Choice Health™** (Alaska)

	DEDUCTIBLE		OUT OF POCKET MAX	
	In-Net.	Out-of-Net.	In-Net.	Out-of-Net.
Medical, Rx, and Vision	\$XXX	\$X,XXX	\$X,XXX	\$XX,XXX

**MEDICAL BENEFITS, PRIOR AUTHORIZATION, & ELIGIBILITY:**  
Members 555-555-5555 | CS@PacificSource.com  
Providers 555-555-5555 | CS@PacificSource.com  
**DENTAL:** 555-555-5555 | Dental@PacificSource.com  
**24-HOUR NURSELINE:** 855-834-6150  
**PHARMACISTS:** 844-834-6150 | Fax 541-225-3665

Verify benefits at [InTouch.PacificSource.com](https://InTouch.PacificSource.com)  
PacificSource Health Plans | PO Box 7068, Springfield, OR 97475-0068  
This card is not an authorization for services or a guarantee of payment.

## Outside the Northwest?



With **Navigator**, your in-network coverage goes with you thanks to partnerships with **First Health®** and **First Choice Health.™**

# 2023 Idaho | Navigator Small Group Medical Plans

																			HSA-QUALIFIED PLANS															
		Gold 600^		Gold 1000^		Gold 2000^		Silver 3000^		Silver 4500^		Silver 5500^		Silver 6500^		Bronze 6800^		Bronze 9100^		Gold HSA 3000**		Silver HSA 3000**		Silver HSA 4000**		Silver HSA 4800**		Silver HSA 5500**		Bronze HSA 7050**				
		IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK			
Deductible Individual / Family		\$600/ \$1,200	\$10,000 / \$20,000	\$1,000 / \$2,000	\$10,000 / \$20,000	\$2,000 / \$4,000	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$4,500 / \$9,000	\$10,000 / \$20,000	\$5,500 / \$11,000	\$10,000 / \$20,000	\$6,500 / \$13,000	\$10,000 / \$20,000	\$6,800 / \$13,600	\$10,000 / \$20,000	\$9,100 / \$18,200	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$4,000 / \$8,000	\$10,000 / \$20,000	\$4,800 / \$9,600	\$10,000 / \$20,000	\$5,500 / \$11,000	\$10,000 / \$20,000	\$7,050 / \$14,100	\$10,000 / \$20,000			
Out-of-Pocket Maximum Individual / Family		\$7,500/ \$15,000	\$15,000 / \$30,000	\$6,600 / \$13,200	\$15,000 / \$30,000	\$5,500 / \$11,000	\$15,000 / \$30,000	\$9,100 / \$18,200	\$15,000 / \$30,000	\$9,100 / \$18,200	\$15,000 / \$30,000	\$9,100 / \$18,200	\$15,000 / \$30,000	\$9,100 / \$18,200	\$15,000 / \$30,000	\$8,200 / \$16,400	\$15,000 / \$30,000	\$9,100 / \$18,200	\$15,000 / \$30,000	\$3,000 / \$6,000	\$15,000 / \$30,000	\$7,050 / \$14,100	\$15,000 / \$30,000	\$6,000 / \$12,000	\$15,000 / \$30,000	\$4,800 / \$9,600	\$15,000 / \$30,000	\$5,500 / \$11,000	\$15,000 / \$30,000	\$7,050 / \$14,100	\$15,000 / \$30,000			

Preventive Services	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible
Accident Benefit	Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.		Covered in full up to \$500, within 90 days of accident.	

Office Visits Primary, Urgent Care, and Specialist (including behavioral health for adults)	Primary/Urgent Care: \$40 no deductible  Specialist: \$80 no deductible	50% after deductible	Primary/Urgent Care: \$30 no deductible  Specialist: \$60 no deductible	50% after deductible	Primary/Urgent Care: \$30 no deductible  Specialist: \$60 no deductible	50% after deductible	Primary/Urgent Care: \$50 no deductible  Specialist: \$100 no deductible	50% after deductible	Primary/Urgent Care: \$40 no deductible  Specialist: \$80 no deductible	50% after deductible	Primary/Urgent Care: \$35 no deductible  Specialist: \$70 no deductible	50% after deductible	Primary/Urgent Care: \$35 no deductible  Specialist: \$70 no deductible	50% after deductible	Primary/Urgent Care: \$35 no deductible  Specialist: \$70 after deductible	50% after deductible	Primary/Urgent Care: \$40 no deductible  Specialist: \$80 no deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Telehealth	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible	25% after deductible	50% after deductible	25% after deductible	50% after deductible	40% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	50% after deductible	25% after deductible	50% after deductible	25% after deductible	50% after deductible	40% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	\$40 no deductible	50% after deductible	\$30 no deductible	50% after deductible	\$30 no deductible	50% after deductible	\$50 no deductible	50% after deductible	\$40 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$35 no deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	25% after deductible	50% after deductible	25% after deductible	50% after deductible	40% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Emergency Services	\$250 plus 20% after deductible	\$250 plus 20% after deductible	\$250 plus 25% after deductible	\$250 plus 25% after deductible	\$250 plus 25% after deductible	\$250 plus 25% after deductible	\$250 plus 40% after deductible	\$250 plus 40% after deductible	\$250 plus 35% after deductible	\$250 plus 35% after deductible	\$250 plus 30% after deductible	\$250 plus 30% after deductible	\$250 plus 30% after deductible	\$250 plus 30% after deductible	\$500 plus 40% after deductible	\$500 plus 40% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	20% after deductible	20% after deductible	10% after deductible	10% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible
Chiropractic / Acupuncture 18 visits combined per benefit period	\$40 no deductible	50% after deductible	\$30 no deductible	50% after deductible	\$30 no deductible	50% after deductible	\$50 no deductible	50% after deductible	\$40 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$40 no deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15 no deductible Tier 2: \$45 no deductible Tier 3 & 4: 20% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$45 no deductible Tier 3 & 4: 20% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$45 no deductible Tier 3 & 4: 20% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$90 no deductible Tier 3 & 4: 40% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3 & 4: 35% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3 & 4: 30% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3 & 4: 30% no deductible	50% after deductible	40% after deductible	50% after deductible	Tier 1: \$20 no deductible Tier 2, 3, & 4: 0% after deductible	50% after deductible	0% after deductible	50% after deductible	20% after deductible	50% after deductible	10% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible

^Adult vision included on this plan.  
\*\*Includes adult vision exams.  
Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. Benefit subject to deductible and coinsurance. Treatment for autism spectrum disorder is covered the same as other conditions, depending on the services rendered. Visit limits do not apply to treatment for autism spectrum disorder.  
This is a brief summary. Contact us at [IdahoSales@PacificSource.com](mailto:IdahoSales@PacificSource.com) or go to [PacificSource.com](https://www.pacificsource.com) for details or to see a plan's Summary of Benefits. Accessibility help: for assistance reading this chart or the rest of the document, please call us at **888-977-9299**, TTY: 711. We accept all relay calls.

Decide on  
dental

Good dental health can lead to better overall health.

You can group our dental plans with your health plans, or select dental-only.

Dental options to fit your company’s needs

Our Dental Choice and Choice Plus plans allow your employees to visit any dental provider, while our Dental Advantage plans feature different benefit levels for in- and out-of-network dental visits.

With our Voluntary Dental option, your employees pay the full premium as if they were buying their own dental plan, but they get plan benefits that typically come with a group plan.

Voluntary Dental is available with our non-Plus plans to groups with 10 or more enrolled employees. Additional guidelines and requirements apply.

2023 Idaho | Small Group Dental Plans

	Dental Choice 0-20-50 50-1000 or 0-20-50 50-1500	Dental Choice Plus 0-20-50 25-1000 or 0-20-50 25-1500	Dental Choice Plus 0-20-50 50-1000 or 0-20-50 50-1500	Dental Advantage Core		Dental Advantage 0-20-50 750		Dental Advantage 0-20-50 1000 or 0-20-50 1500		Dental Advantage Plus 0-20-50 1000 or 0-20-50 1500		Kids Dental Advantage 0-20-50 or 20-40-50 <small>(coverage for members age 18 and under)</small>	
	No network needed	No network needed	No network needed	Advantage Network		Advantage Network		Advantage Network		Advantage Network		Advantage Network	
Group Size Required for Standalone Policy	2+	2+	2+	2+		2+		2+		2+		2+	
	ANY PROVIDER	ANY PROVIDER	ANY PROVIDER	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Annual Deductible Individual / Family	\$50 / \$150	\$25 / \$75	\$50 / \$150	N/A	\$50 / \$150	N/A	\$50 / \$150	N/A	\$50 / \$150	N/A	\$50 / \$150	N/A	\$50 / \$150
Annual Maximum Benefit Per person, age 19 and older	\$1,000 or \$1,500	\$1,000 or \$1,500	\$1,000 or \$1,500	\$500 on Class II services		\$750		\$1,000 or \$1,500		\$1,000 or \$1,500		N/A	
Pediatric Out-of-Pocket Maximum Individual/Family, age 18 and under	\$375 / \$750	\$375 / \$750	\$375 / \$750	\$375 / \$750		\$375 / \$750		\$375 / \$750		\$375 / \$750		\$375 / \$750	
	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:
Class I Services	Covered in full	Covered in full	Covered in full	Covered in full	20%	Covered in full	20%	Covered in full	20%	Covered in full	20%	Covered in full or 20%	20%
	AFTER DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:
Class II Services	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20% or 40%	20% or 50%
Class III Services	50%	50%	50%	50% (age 19+ not covered)	50% (age 19+ not covered)	50%	50%	50%	50%	50%	50%	50%	50%
Adult Exclusion Period Per person, age 19 and older	Class III: 12 months	None	None	Class II: 6 months		Class II: 6 months; Class III: 12 months		Class III: 12 months		None		None	
Cosmetic Orthodontia*	Optional; \$1,000 Lifetime Max	Optional; \$1,000 Lifetime Max	Optional; \$1,000 Lifetime Max	N/A		Optional; \$1,000 Lifetime Max		Optional; \$1,000 Lifetime Max		Optional; \$1,000 Lifetime Max		N/A	

\*Additional eligibility requirements may apply.  
This is a brief summary. For more details, contact us at [IdahoSales@PacificSource.com](mailto:IdahoSales@PacificSource.com) or search small group plans at [PacificSource.com](https://www.pacificsource.com). Accessibility help: for assistance reading this chart or the rest of the document, please call us at 888-977-9299, TTY: 711. We accept all relay calls.

What’s covered?

Here is a brief list of services and treatments most commonly asked about. Go to [PacificSource.com](https://www.pacificsource.com) to get all the details.

Class I: Preventive Services

- Exams and x-rays
- Dental cleanings (prophylaxis or periodontal maintenance)
- Fluoride applications
- Sealant on bicuspid and permanent molars (kids through age 18 only)
- Brush biopsies

Class II: Basic Services

- Simple extractions
- Periodontal scaling and root planing and/or curettage
- Full mouth debridement
- Fillings, including composite
- Complicated oral surgery
- Endodontic (pulp therapy and root canal therapy)
- Periodontal surgery

Class III: Major Services

- Full, immediate, or overdentures
- Crowns and bridges
- Child orthodontia (medically necessary only; all plans; kids through age 18)

Cosmetic Orthodontia

- Available to groups with 26-50 enrolled employees
- Available with any dental plan purchased direct through PacificSource (except Core and Kids plans)
- \$1,000 lifetime max, 12-month wait period; wait period reduced or eliminated with prior orthodontia coverage

Focus on  
vision

Our vision plans focus on wellness and prevention.

Vision for kids

All of our medical plans include full coverage for in-network pediatric eye exams. Out-of-network eye exams are covered up to \$40 with no deductible. After that, the member pays 100%. Pediatric vision hardware is covered in full up to \$150. After that, it’s subject to an in-network deductible and then a cost-share fee up to 50%, depending on the plan.

Vision for adults

All of our medical plans include coverage for adult eye exams, and many include coverage for vision hardware such as eyeglasses or contacts. Please see the plan comparison chart following page 10. Plans with the ^ symbol include adult vision.

For more details on our vision benefits, please contact your broker or our team at the contact information listed on the back of this brochure.

# Choose **one plan, or more**



**All our plans are designed to help members feel well and stay healthy, including benefits for preventive care, \$0 annual physicals, and most vaccinations.**

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## **Right Fit**

Our Right Fit options let your employees choose the premium and coverage that suit them best.

- Employees may choose from two to four different products.
- There's no minimum enrollment, but the number of plans you offer can't exceed the number of enrolling employees.
- Employees can change products during open enrollment.
- Minimum employer contribution: 50% employee/0% dependents of your lowest-cost plan.

Underwriting guidelines apply.

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## **HSA**

### Health Savings Accounts (HSA) are a win-win

HSA-qualified plans help employees save money for healthcare expenses, such as deductibles and coinsurance. They also help employers save premium dollars—and your contributions to HSA accounts are exempt from payroll taxes.

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## **HRA**

### Health Reimbursement Arrangements (HRA) to combat costs

With an HRA, you reimburse some of your employees' medical expenses. You control how much to contribute and which types of expenses are eligible. And if you choose PacificSource Administrators, they can take care of claims filing and reimbursement through Easy Pay.

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# At a glance your PacificSource coverage includes:



No-cost wellness programs to encourage employee fitness, nutrition, and behavioral health



Education reimbursement up to \$150 for health and wellness classes



Pediatric vision benefits with all plans, and adult vision on a select few



No-cost care management for chronic conditions



Affordable fitness center access from our partner, Active&Fit Direct™



Prenatal program for expectant parents



Easy online access for you and your employees



\$500 accident benefit for covered services due to an accident outside of work



Home delivery of prescriptions—up to a 90-day supply



24-Hour NurseLine at no cost



Worry-free travel with global emergency services from Assist America®

Additional benefits are not considered insurance.

# Next steps:



## Choose a health plan or plans

Shop online at  
[PacificSource.com/shop-plans/employers/small-group](https://PacificSource.com/shop-plans/employers/small-group)



## Decide on dental



## Enroll

Contact your broker

or call us at

**855-972-3121**, TTY: 711

We accept all relay calls

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## **We're here to help.**

We know that each step may require guidance,  
so please contact us with any questions.

**Monday through Friday from 8:00 a.m. to 5:00 p.m.**

**Phone:** 855-972-3121

**TTY:** 711. We accept all relay calls.

**Email:** [IdahoSales@PacificSource.com](mailto:IdahoSales@PacificSource.com)

[PacificSource.com](http://PacificSource.com)

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# Idaho medical plans

## 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 medical 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.

Below is a complete list of services and treatments that are not covered under our medical plans.

- Abdominoplasty for any indication.
- Academic skills training.
- Acute care, rehabilitative, diagnostic testing, except as specified as a Covered Service in this policy.
- Athletic activities – Any injuries sustained while competing or practicing for a professional athletic contest.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted with the Provider.
- Charges that are the responsibility of a third party who may have caused the Illness or Injury, or other insurers covering the incident (such as workers' compensation insurers and no fault automobile or premises insurers). For more information, see the Third Party Liability section.
- Chelation therapy including associated infusions of vitamins and/or minerals, except as Medically Necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions, or related data.
- Cosmetic/reconstructive services and supplies – Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes and any complications as a result of non-covered cosmetic/reconstructive surgery. Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of a Congenital Anomaly or gender dysphoria.
- Court-ordered screening interviews or drug or alcohol treatment programs.
- Court-ordered sex offender treatment programs.
- Day care or Custodial Care, including non-skilled care and helping with activities of daily living, except as specified above in conjunction with Home Healthcare or Hospice Care.
- Dental examinations and treatment to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including treatment that restores the function of teeth.
- Drugs or medications that can be self-administered (including Prescription Drugs, injectable drugs, and biologicals), except when prescribed for inborn errors of metabolism, formulary diabetic insulin, autism spectrum disorder, or unless given during a visit for outpatient Chemotherapy or dialysis or during a Medically Necessary Hospital, emergency room, or other institutional stay.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.
- Elective Abortions. For more information, see Elective Abortion in the Definitions section.
- Equine/animal therapy.
- Equipment commonly used for nonmedical purposes and/or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- 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.

- Eye examinations (preventive) for Members age 19 and older.
- Eye exercises and eye refraction, therapy, and procedures.
- Eye glasses/Contact Lenses for Members age 19 and older – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Eye orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Fitness or exercise programs and health or fitness club memberships.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Hearing Aids including the fitting, provision, or replacement of Hearing Aids. For more information, see the Durable Medical Equipment section.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy except in the treatment of Mental Health Conditions.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – Services and supplies for artificial insemination, in vitro fertilization, treatment of Infertility, erectile dysfunction, sexual dysfunction, or surgery to reverse voluntary sterilization. Services and supplies, diagnostic laboratory and x-ray studies, surgery, treatment, or Prescription Drugs to diagnose, prevent, or cure Infertility or to induce fertility (including Gamete and/or Zygote Intrafallopian Transfer; such as GIFT or ZIFT), except for medication to preserve fertility during treatment with cytotoxic Chemotherapy.
- Inpatient or outpatient Custodial Care; or inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service in this policy.
- Instructional or educational programs, except diabetes self-management programs when Medically Necessary.
- Jaw – Procedures, services, and supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services and supplies that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing, or chewing; cosmetic procedures and procedures to improve on the normal range of functions; and dentures, Prosthetic Devices for treatment of TMJ conditions and artificial larynx. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Jaw surgery – Treatment for malocclusion of the jaw, including services for TMJ, anterior and internal dislocations, derangements and myofascial pain syndrome, orthodontics or related appliances, or improving the placement of dentures and dental implants. (This does not include services for Congenital Anomalies as defined in the Definitions section.)
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Massage or massage therapy, even as part of a physical therapy program.
- Mattresses and mattress pads unless Medically Necessary to heal pressure sores.
- Mental health treatments for conditions defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders, that are not attributable to a mental health disorder or disease.
  - Mental Illness does not include – relationship problems (for example, parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse, neglect of a child, or bereavement.
  - Unless Medically Necessary, the following are excluded: court-mandated diversion and/or Substance Use Disorder education classes; court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous; adolescent wilderness treatment programs; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a Mental Health Condition; stress management, parenting skills, or family education; and assertiveness training.
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition.
- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including Provider review.
- Naturopathic supplies.
- Nicotine related disorder treatment, other than those covered through Tobacco Cessation Program services.
- Non-Dependent newborn – For the purpose of this policy, a newborn will not be considered an eligible Dependent if the Member has entered into a contract or other understanding to which the newborn is being relinquished to the intended parents at birth.
- Obesity or weight reduction control – Surgery or other related services or supplies provided for weight reduction control or obesity (including all categories of obesity), when not Medically Necessary to control other medical conditions that are eligible for Covered Services and nonsurgical methods have been unsuccessful in treating obesity. This also includes services or supplies used for weight loss, such as food supplementation programs and behavior modification programs, and self-help or training programs for weight reduction control. Obesity screening and counseling are covered for children and adults. For more information, see dietary or nutritional counseling in the Professional Services section.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except to repair an

Accidental Injury or for removal of a malignancy, including reconstruction of the jaw.

- Orthopedic shoes, diabetic shoes, and shoe modifications.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system.
- Over-the-counter medications or non-Prescription Drugs, unless included on your Drug List or is otherwise listed as a Covered Service in this policy. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy (removal of panniculus, or excess skin, from lower abdomen) for any indication.
- Paraphilias.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition, except for diabetic education benefit.
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with an autism spectrum disorder.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.
- Sensory integration training.
- Services for which no charge is normally made in the absence of insurance.
- 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 not listed as a Covered Service, unless required under federal or state 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 service provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, alteration of the physical environment, or education of a patient. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy. For related provisions, see Infertility and mental health in this section.
- Social skills training.
- Support groups.
- Temporomandibular joint (TMJ) – Related services, or treatment for associated myofascial pain including physical or orofacial therapy. Advice or treatment, including physical therapy and/or orofacial therapy, either directly or indirectly for temporomandibular joint dysfunction, myofascial pain, or any related appliances. For related provisions, see jaw and orthognathic surgery in this section and in the Professional Services section.
- Transplants – Any services, treatments, or supplies for the transplantation of bone marrow or peripheral blood stem cells or any human body organ or tissue, except as expressly provided under the provisions of this policy for covered transplantation expenses.
- Treatment after insurance ends – Services or supplies a Member receives after the Member's coverage under this policy ends, except as follows:
  - (Small group only: If the Member is pregnant and not eligible for any replacement group coverage within 60 days, this plan's maternity benefits may continue for up to 12 months. PacificSource will then provide maternity benefits to the extent they are covered in this plan for up to 12 months after this plan is discontinued.
  - If the Member is Totally Disabled, coverage may continue for up to 12 months. PacificSource will continue to provide benefits for covered expenses related to disabling conditions until the Member is no longer Totally Disabled, the plan's maximum benefits have been paid, or the plan coverage has been discontinued for 12 months.)
- Treatment not Medically Necessary – Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.

- Treatment of any Illness or Injury arising out of an illegal act or occupation or participation in a felony.
- Treatment of any work-related Illness or Injury except as described in On-the-Job Illness or Injury and Workers' Compensation.
- Treatment of intellectual disabilities, as defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders. Intellectual disability means a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.
- Treatment prior to enrollment.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release medical 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.
- Certain drugs are subject to Step Therapy (ST) protocols, which means we may require you to try a pre-requisite drug before we will pay for the requested drug. An up-to-date list of drugs requiring Step Therapy along with all of our requirements is available on our website.
- Certain drugs have quantity limits (QL), which means we will generally not pay for quantities above posted limits. An up-to-date list of drugs requiring quantity limit exceptions along with all of our requirements is available on our website.
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. PacificSource will not approve early refills, except under the following circumstances:
  - The request is for ophthalmic solutions or gels, refillable after 70 percent of the previous supply has been taken.
  - The Member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.

## Prescription drug exclusions

- This policy only covers drugs prescribed by eligible Providers prescribing within the scope of their professional licenses. This policy does not cover the following:
  - Drugs for any condition excluded under the medical policy.
  - Some Specialty Drugs that are not self-administered are not covered by this prescription benefit, but may be covered under the medical policy's office supply benefit. For a list of drugs that are covered under your medical benefit and which may require prior authorization, please refer to the medical authorization grid on our website, [Authgrid.PacificSource.com](http://Authgrid.PacificSource.com) (select Commercial for the line of business).
  - Some immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include, but not limited to: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your Provider under your medical benefit.
  - Some drugs and all devices to treat erectile or sexual dysfunction unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
  - Drugs used as a preventive measure against hazards of travel.
  - Vitamins, minerals, and dietary supplements except for prescription prenatal vitamins, fluoride products, and for drugs that have a rating of A or B from the USPSTF, some restrictions may apply.
- Certain drugs require prior authorization (PA). An up-to-date list of drugs requiring prior authorization along with all of our requirements is available on our website.

All early refills are subject to standard cost share and are reviewed on a case-by-case basis. A pharmacist can approve an early refill of a prescription for eye drops as required by law.

## 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 health benefit policies within the state of issuance or in a specific area within the state. Discontinuation of all individual health benefit policies are subject to notification at least 180 days in advance of discontinuation of the policies;
- When PacificSource discontinues offering or renewing this policy within the state of issuance because of an inability to reach an agreement with the Providers or organization of Providers to provide services under this policy within the Service Area. Discontinuation of this policy is subject to notification at least 90 days in advance of discontinuation of this 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 and the termination of coverage is not related to the health status of any Member; or
- When the Policyholder terminates the policy on any premium due date with 15 days prior written notice.

## Renewability of small group policy

- Policy renewal. The policy is renewable with respect to all eligible members at the option of the policyholder, unless:
  - The policyholder fails to pay the required premium. Termination is effective on the last day of the last month for which premium was paid.
  - The policyholder with respect to coverage of individual members, or the policyholder's or member's representative engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan.
  - The number of members is less than the number or percentage of eligible employees required by the policy's participation requirements.
  - The policyholder fails to maintain the minimum employer premium contribution required.
  - PacificSource elects not to renew all of its benefit plans delivered or issued in the small group market in your state, provided all of the following conditions are satisfied:
    - Advance notice of the decision is provided to the Department of Insurance and to all policyholders; and
    - Notice of the decision to all affected policyholders at least 180 days prior to the nonrenewal of any plans.
  - The employer no longer satisfies the definition of a small employer.
  - The Department of Insurance finds continuation of this policy's coverage would not be in the interest of the members, or would impair PacificSource's ability to meet contractual obligations.
  - In the case of a group benefit plan that delivers covered services through a specified network of providers, there is no longer any member who lives, resides, or works in the service area of the provider network.
  - In the case of a benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any member.
  - PacificSource elects to no longer offer a benefit plan for any reason, a notice will be sent to the policyholder within 90 days of discontinuance of plan.
  - The policyholder terminates the policy on any premium due date with a 30 day prior written notice to PacificSource.

## 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.

# Idaho dental plans for small groups (2–50)

## 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.
- Bone replacement grafts to prepare sockets for implants after tooth extraction for Members age 19 and older on certain plan designs.
- 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.
- Comprehensive periodontal exams 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.)
- Crowns and other cast or laboratory processed restorations for Members age 19 and older on certain plan designs.
- 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.
- Dentures, including cast partial denture, full, immediate, or overdenture for Members age 19 and older on certain plan designs.
- Diagnostic casts (study models) and occlusal appliances 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.
- Fixed bridges or removable cast partials for Members age 19 and older on certain plan designs.

- 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.
- Implants – Surgical preparation, surgical placement, or removal of implants for Members age 19 and older on certain plan designs.
- 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, except to repair an Accidental Injury or for removal of a malignancy, including reconstruction of the 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.
- Replacement of an existing prosthetic device for Members age 19 and older on certain plan designs.
- 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 small group policy

- Policy renewal. The policy is renewable with respect to all eligible members at the option of the policyholder, unless:
  - The policyholder fails to pay the required premium. Termination is effective on the last day of the last month for which premium was paid.
  - The policyholder with respect to coverage of individual members, or the policyholder's or member's representative engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan.
  - The number of members is less than the number or percentage of eligible employees required by the policy's participation requirements.
  - The policyholder fails to maintain the minimum employer premium contribution required.
  - PacificSource elects not to renew all of its benefit plans delivered or issued in the small group market in your state, provided all of the following conditions are satisfied:
    - Advance notice of the decision is provided to the Department of Insurance and to all policyholders; and
    - Notice of the decision to all affected policyholders at least 180 days prior to the nonrenewal of any plans.
  - The employer no longer satisfies the definition of a small employer.
  - The Department of Insurance finds continuation of this policy's coverage would not be in the interest of the members, or would impair PacificSource's ability to meet contractual obligations.
  - In the case of a group benefit plan that delivers covered services through a specified network of providers, there is no longer any member who lives, resides, or works in the service area of the provider network.
  - In the case of a benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any member.
  - PacificSource elects to no longer offer a benefit plan for any reason, a notice will be sent to the policyholder within 90 days of discontinuance of plan.
  - The policyholder terminates the policy on any premium due date with a 30 day prior written notice to PacificSource.

# 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.