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# 2023 Medical Plans for **Idaho Individuals and Families**

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# 2023 Idaho | Navigator Individual and Family Medical Plans

	HSA-QUALIFIED PLANS													
	Gold 2500		Silver 3600		Bronze 6000		Bronze 9100		Catastrophic^		Silver HSA 3500		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
Deductible Individual/Family	\$2,500 / \$5,000	\$10,000 / \$20,000	\$3,600 / \$7,200	\$10,000 / \$20,000	\$6,000 / \$12,000	\$10,000 / \$20,000	\$9,100 / \$18,200	\$10,000 / \$20,000	\$9,100 / \$18,200	\$10,000 / \$20,000	\$3,500 / \$7,000	\$10,000 / \$20,000	\$7,050 / \$14,100	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual/Family	\$6,000 / \$12,000	\$85,500 / \$171,000	\$9,100 / \$18,200	\$85,500 / \$171,000	\$8,550 / \$17,100	\$85,500 / \$171,000	\$9,100 / \$18,200	\$85,500 / \$171,000	\$9,100 / \$18,200	\$85,500 / \$171,000	\$6,700 / \$13,400	\$85,500 / \$171,000	\$7,050 / \$14,100	\$85,500 / \$171,000

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
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
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	

Office Visits Primary (including behavioral health), Urgent Care, and Specialist	Primary/Urgent: \$25 no deductible  Specialist: \$50 no deductible	50% after deductible	Primary/Urgent: \$35 no deductible  Specialist: \$70 after deductible	50% after deductible	Primary/Urgent: \$35 no deductible  Specialist: \$70 after deductible	50% after deductible	Primary/Urgent: \$50 no deductible  Specialist: \$100 no deductible	50% after deductible	Visits 1-3 no deductible, covered in full Visits 4+ 0% after deductible  Urgent Care/Specialist: 0% after deductible	50% after deductible	25% 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	Visits 1-3 no deductible, covered in full Visits 4+ 0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Lab / X-ray	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 18 visits per benefit period	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Emergency Services	10% after deductible	10% after deductible	40% after deductible	40% after deductible	50% after deductible	50% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	25% after deductible	25% after deductible	0% after deductible	0% after deductible
Chiropractic / Acupuncture 18 visits per benefit period	\$25 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$35 no deductible	50% after deductible	\$50 no deductible	50% after deductible	0% after deductible	50% after deductible	25% 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: \$60 no deductible Tier 3 & 4: 10% no deductible	50% after deductible	Tier 1: \$15 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 40% no deductible	50% after deductible	Tier 1: \$25 no deductible Tier 2, 3, & 4: 50% 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	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Pediatric Eye Exam	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40	0% after deductible	50% after deductible	Covered in full	Covered in full up to \$40	Covered in full	Covered in full up to \$40
Pediatric Vision Hardware	Covered in full up to \$150, then subject to in-network deductible and 10%		Covered in full up to \$150, then subject to in-network deductible and 40%		Covered in full up to \$150, then subject to in-network deductible and 50%		Covered in full up to \$150, then subject to in-network deductible		0% after deductible	50% after deductible	Covered in full up to \$150, then subject to in-network deductible and 25%		Covered in full up to \$150, then subject to in-network deductible	

^Only available for people under 30, or people of any age with a hardship exemption or affordability exemption.  
Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. 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 a Coverage Advisor at **855-330-2792** or by email at [CoverageAdvisors@PacificSource.com](mailto:CoverageAdvisors@PacificSource.com). 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 **855-330-2792**, TTY: 711. We accept all relay calls.

# Availability map **by county**

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For more information, contact a Coverage Advisor at  
**855-672-2772**, TTY: 711 (we accept all relay calls),  
or by email at [CoverageAdvisors@PacificSource.com](mailto:CoverageAdvisors@PacificSource.com).