PacificSource HEALTH PLANS

2025 Idaho Navigator Individual and Family Medical Plans

	Gold 2500	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$2,500 / $5,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$6,000 / $12,000**	**$85,500 / $171,000**
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	50% after deductible
Accident Benefit	Covered in full up to $500 within 90 days of accident	
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $25 no deductible Specialist: $50 no deductible	50% after deductible
Telehealth	$25 no deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible
Lab / X-ray	10% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 18 visits per benefit period	10% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Emergency Services	10% after deductible	10% after deductible
Chiropractic / Acupuncture 18 visits per benefit period	$25 no 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 after deductible Tier 3: 10% after deductible Tier 4: 10% after deductible	50% after deductible
Pediatric Eye Exam	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%	

Plans available to residents of 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 Counties.

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 **855-672-2772** or by email at CoverageAdvisors@PacificSource.com. Go to PacificSource.com for details or to see a plan's Summary of Benefits.

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PacificSource HEALTH PLANS

2025 Idaho Navigator Individual and Family Medical Plans

	Silver 3600	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$3,600 / $7,200**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$85,500 / $171,000**
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	50% after deductible
Accident Benefit	Covered in full up to $500 within 90 days of accident	
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $25 no deductible Specialist: $70 no deductible	50% after deductible
Telehealth	$25 no deductible	50% after deductible
Inpatient Hospital	40% after deductible	50% after deductible
Lab / X-ray	40% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 18 visits per benefit period	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Emergency Services	40% after deductible	40% after deductible
Chiropractic / Acupuncture 18 visits per benefit period	$25 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $10 no deductible Tier 2: $60 after deductible Tier 3: 40% after deductible Tier 4: 40% after deductible	50% after deductible
Pediatric Eye Exam	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 40%	

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PacificSource HEALTH PLANS

2025 Idaho Navigator Individual and Family Medical Plans

	Bronze 6000	Bronze 9200	Bronze HSA 8050	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$6,000 / $12,000**	**$9,200 / $18,400**	**$8,050 / $16,100**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$9,200 / $18,400**	**$8,050 / $16,100**	**$85,500 / $171,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Covered in full up to $500 within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $15 no deductible Specialist: $70 after deductible	Primary/Urgent: $50 no deductible Specialist: $100 no deductible	0% after deductible	50% after deductible
Telehealth	$15 no deductible	$50 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	50% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	50% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 18 visits per benefit period	50% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	50% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture 18 visits per benefit period	$15 no deductible	$50 no 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: $25 no deductible Tier 2, 3, & 4: 50% after deductible	Tier 1: $20 no deductible Tier 2, 3, & 4: 0% after deductible	0% after deductible	50% after deductible
Pediatric Eye Exam	Covered in full			Covered in full up to $40
Pediatric Vision Hardware	Bronze 6000: Covered in full up to $150, then subject to in-network deductible and 50% Bronze 9200 and Bronze HSA 8050: Covered in full up to $150, then subject to in-network deductible			

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