PacificSource HEALTH PLANS

2026 Idaho Small Group Medical Plans

	Gold 1000^	Gold 2000^		Gold HSA 3400**	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,000 / $2,000**	**$2,000 / $4,000**	**$15,000 / $30,000**	**$3,400 / $6,800**	**$15,000 / $30,000**
Out-of-Pocket Maximum Individual / Family	**$7,000 / $14,000**	**$7,000 / $14,000**	**$20,000 / $40,000**	**$3,400 / $6,800**	**$20,000 / $40,000**
Preventive Services	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
Accident Benefit	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	Primary/Urgent Care: $30 no deductible Specialist: $60 no deductible	Primary/Telehealth combined visits 1–3: $5 no deductible, visits 4+: $30 no deductible Urgent Care: $30 no deductible Specialist: $70 no deductible	50% after deductible	0% after deductible	50% after deductible
Telehealth	$30 no deductible		50% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	25% after deductible		50% after deductible	0% after deductible	50% after deductible
Lab / X-ray	25% after deductible		50% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	$30 no deductible		50% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	25% after deductible		50% after deductible	0% after deductible	50% after deductible
Emergency Services	25% after deductible			0% after deductible	
Chiropractic / Acupuncture 18 visits combined per benefit period	$30 no 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: 20% no deductible Tier 4: 20% no deductible		50% after deductible	0% after deductible	50% after deductible

^Adult vision exam and hardware benefit included on this plan.
**Includes adult vision exams only.

Navigator network plans are available to businesses statewide.

Voyager network plans are available to businesses statewide.

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This is a brief summary. Contact us at **877-372-8246,** IdahoSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.

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PacificSource HEALTH PLANS

2026 Idaho Small Group Medical Plans

	Silver 3300^	Silver 4500^	Silver 5500^	Silver HSA 5300**	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$3,300 / $6,600**	**$4,500 / $9,000**	**$5,500 / $11,000**	**$5,300 / $10,600**	**$15,000 / $30,000**
Out-of-Pocket Maximum Individual / Family	**$9,100 / $18,200**	**$9,800 / $19,600**	**$10,600 / $21,200**	**$5,300 / $10,600**	**$20,000 / $40,000**
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/Telehealth combined visits 1–3: $5 no deductible, visits 4+: $50 no deductible Urgent Care: $50 no deductible Specialist: $100 no deductible	Primary Care: $40 no deductible Urgent Care: $60 no deductible Specialist: $80 no deductible	Primary Care: $35 no deductible Urgent Care: $55 no deductible Specialist: $70 no deductible	0% after deductible	50% after deductible
Telehealth		$40 no deductible	$35 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	35% after deductible	30% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	35% after deductible	30% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	$50 no deductible	$40 no deductible	$35 no deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	35% after deductible	30% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	35% after deductible	30% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture 18 visits combined per benefit period	$50 no deductible	$40 no deductible	$35 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: $15 no deductible Tier 2: $90 after deductible Tier 3: 40% after deductible Tier 4: 40% after deductible	Tier 1: $15 no deductible Tier 2: $70 no deductible Tier 3: 35% no deductible Tier 4: 35% no deductible	Tier 1: $15 no deductible Tier 2: $70 no deductible Tier 3: 30% no deductible Tier 4: 30% no deductible	0% after deductible	50% after deductible

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	Bronze 6800^	Bronze 7600^	Bronze 10600^	Bronze HSA 8300**	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$6,800 / $13,600**	**$7,600 / $15,200**	**$10,600 / $21,200**	**$8,300 / $16,600**	**$15,000 / $30,000**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$9,800 / $19,600**	**$10,600 / $21,200**	**$8,300 / $16,600**	**$20,000 / $40,000**
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 Care: $35 no deductible Urgent Care: $100 no deductible Specialist: $70 no deductible	Primary/Telehealth combined visits 1–3: $5 no deductible, visits 4+: $50 no deductible Urgent Care: $100 no deductible Specialist: $150 no deductible	Primary Care: $75 no deductible Urgent Care: $100 no deductible Specialist: $80 no deductible	0% after deductible	50% after deductible
Telehealth	$35 no deductible		$75 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	40% after deductible	$50 no deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	40% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture 18 visits combined per benefit period	$35 no deductible	$50 no deductible	$75 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	40% after deductible	Tier 1: $30 no deductible Tier 2, 3, & 4: 40% after deductible	Tier 1: $35 no deductible Tier 2, 3, & 4: 0% after deductible	0% after deductible	50% after deductible

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