PacificSource HEALTH PLANS

# 2024 Idaho Navigator Small Group Medical Plans

| | Platinum 500^ | |
|---|---|---|
| | IN NETWORK | OUT OF NETWORK |
| **Deductible** Individual / Family | **$500 / $1,000** | **$10,000 / $20,000** |
| **Out-of-Pocket Maximum** Individual / Family | **$3,000 / $6,000** | **$15,000 / $30,000** |
| **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 Care: $10 no deductible<br>Specialist: $20 no deductible | 50% after deductible |
| **Telehealth** | $10 no deductible | 50% after deductible |
| **Inpatient Hospital** | 20% after deductible | 50% after deductible |
| **Lab / X-ray** | 20% after deductible | 50% after deductible |
| **Physical, Occupational, and Speech Therapy** 20 visits per benefit period | $10 no deductible | 50% after deductible |
| **Outpatient Surgery** | 20% after deductible | 50% after deductible |
| **Emergency Services** | $250 plus 20% after deductible | |
| **Chiropractic / Acupuncture** 18 visits combined per benefit period | $10 no deductible | 50% after deductible |
| **Prescription (Rx) Drug Coverage** Out-of-network: 30-day max fill, no more than 3 per year | Tier 1: $5 no deductible<br>Tier 2: $15 no deductible<br>Tier 3: $50 no deductible<br>Tier 4: $250 no deductible | 50% after deductible |

^Adult vision included on this plan.
**Includes adult vision exams.

Plans are available to businesses statewide.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. Benefits are 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 **888-800-3881,** IdahoSales@PacificSource.com, or go to 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.

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PacificSource HEALTH PLANS

# 2024 Idaho Navigator Small Group Medical Plans

| | Gold 1000^ | Gold 2000^ | | Gold HSA 3200** | |
|---|---|---|---|---|---|
| | IN NETWORK | IN NETWORK | OUT OF NETWORK | IN NETWORK | OUT OF NETWORK |
| **Deductible** Individual / Family | $1,000 / $2,000 | $2,000 / $4,000 | $10,000 / $20,000 | $3,200 / $6,400 | $10,000 / $20,000 |
| **Out-of-Pocket Maximum** Individual / Family | $6,600 / $13,200 | $5,500 / $11,000 | $15,000 / $30,000 | $3,200 / $6,400 | $15,000 / $30,000 |
| **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<br>Specialist: $60 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** | $250 plus 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<br>Tier 2: $45 no deductible<br>Tier 3: 20% no deductible<br>Tier 4: 20% no deductible | | 50% after deductible | 0% after deductible | 50% after deductible |

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**Includes adult vision exams.

Plans are available to businesses statewide.

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PacificSource HEALTH PLANS

# 2024 Idaho Navigator Small Group Medical Plans

| | Silver 3000^ | Silver 4500^ | Silver 5500^ | Silver 6500^ | |
|---|---|---|---|---|---|
| | IN NETWORK | IN NETWORK | IN NETWORK | IN NETWORK | OUT OF NETWORK |
| **Deductible** Individual / Family | **$3,000 / $6,000** | **$4,500 / $9,000** | **$5,500 / $11,000** | **$6,500 / $13,000** | **$10,000 / $20,000** |
| **Out-of-Pocket Maximum** Individual / Family | **$9,100 / $18,200** | **$9,100 / $18,200** | **$9,400 / $18,800** | **$9,100 / $18,200** | **$15,000 / $30,000** |
| **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 Care: $50 no deductible Specialist: $100 no deductible | Primary/Urgent Care: $40 no deductible Specialist: $80 no deductible | Primary/Urgent Care: $35 no deductible Specialist: $70 no deductible | Primary/Urgent Care: $35 no deductible Specialist: $70 no deductible | 50% after deductible |
| **Telehealth** | $50 no deductible | $40 no deductible | $35 no deductible | $35 no deductible | 50% after deductible |
| **Inpatient Hospital** | 40% after deductible | 35% after deductible | 30% after deductible | 30% after deductible | 50% after deductible |
| **Lab / X-ray** | 40% after deductible | 35% after deductible | 30% after deductible | 30% after deductible | 50% after deductible |
| **Physical, Occupational, and Speech Therapy** 20 visits per benefit period | $50 no deductible | $40 no deductible | $35 no deductible | $35 no deductible | 50% after deductible |
| **Outpatient Surgery** | 40% after deductible | 35% after deductible | 30% after deductible | 30% after deductible | 50% after deductible |
| **Emergency Services** | $250 plus 40% after deductible | $250 plus 35% after deductible | $250 plus 30% after deductible | $250 plus 30% after deductible | Same as in-network |
| **Chiropractic / Acupuncture** 18 visits combined per benefit period | $50 no deductible | $40 no deductible | $35 no deductible | $35 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: $90 no deductible Tier 3: 40% no deductible Tier 4: 40% no 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 | Tier 1: $15 no deductible Tier 2: $70 no deductible Tier 3: 30% no deductible Tier 4: 30% no deductible | 50% after deductible |

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**Includes adult vision exams.

Plans are available to businesses statewide.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. Benefits are 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.

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PacificSource HEALTH PLANS

# 2024 Idaho Navigator Small Group Medical Plans

| | Silver HSA 3500** | Silver HSA 5100** | |
|---|---|---|---|
| | IN NETWORK | IN NETWORK | OUT OF NETWORK |
| **Deductible** Individual / Family | $3,500 / $7,000 | $5,100 / $10,200 | $10,000 / $20,000 |
| **Out-of-Pocket Maximum** Individual / Family | $7,500 / $15,000 | $5,100 / $10,200 | $15,000 / $30,000 |
| **Preventive Services** | Covered in full | Covered in full | 50% after deductible |
| **Preventive Drug Coverage** | Covered in full | 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** | 20% after deductible | 0% after deductible | 50% after deductible |
| **Telehealth** | 20% after deductible | 0% after deductible | 50% after deductible |
| **Inpatient Hospital** | 20% after deductible | 0% after deductible | 50% after deductible |
| **Lab / X-ray** | 20% after deductible | 0% after deductible | 50% after deductible |
| **Physical, Occupational, and Speech Therapy** 20 visits per benefit period | 20% after deductible | 0% after deductible | 50% after deductible |
| **Outpatient Surgery** | 20% after deductible | 0% after deductible | 50% after deductible |
| **Emergency Services** | 20% after deductible | 0% after deductible | Same as in-network |
| **Chiropractic / Acupuncture** 18 visits combined per benefit period | 20% 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 | 20% after deductible | 0% after deductible | 50% after deductible |

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PacificSource HEALTH PLANS

# 2024 Idaho Navigator Small Group Medical Plans

| | Bronze 6800^ | Bronze 9400^ | Bronze HSA 7500** | |
|---|---|---|---|---|
| | IN NETWORK | IN NETWORK | IN NETWORK | OUT OF NETWORK |
| **Deductible** Individual / Family | **$6,800 / $13,600** | **$9,400 / $18,800** | **$7,500 / $15,000** | **$10,000 / $20,000** |
| **Out-of-Pocket Maximum** Individual / Family | **$8,600 / $17,200** | **$9,400 / $18,800** | **$7,500 / $15,000** | **$15,000 / $30,000** |
| **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 Care: $35 no deductible<br>Specialist: $70 after deductible | Primary/Urgent Care: $50 no deductible<br>Specialist: $100 no deductible | 0% after deductible | 50% after deductible |
| **Telehealth** | $35 no deductible | $50 no deductible | 0% after deductible | 50% after deductible |
| **Inpatient Hospital** | 40% after deductible | 0% after deductible | 0% after deductible | 50% after deductible |
| **Lab / X-ray** | 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 | 0% after deductible | 0% after deductible | 50% after deductible |
| **Outpatient Surgery** | 40% after deductible | 0% after deductible | 0% after deductible | 50% after deductible |
| **Emergency Services** | $500 plus 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 | 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 | $20 no deductible<br>Tier 2, 3, & 4:<br>0% after deductible | 0% after deductible | 50% after deductible |

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