PacificSource HEALTH PLANS

2025 Idaho 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 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	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 Tier 2: $15 no deductible Tier 3: $50 no deductible Tier 4: $250 no 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 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. **Voyager network plans** are available to residents 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

2025 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**	**$10,000 / $20,000**	**$3,400 / $6,800**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$6,600 / $13,200**	**$5,500 / $11,000**	**$15,000 / $30,000**	**$3,400 / $6,800**	**$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 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	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

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**Includes adult vision exams only.

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2025 Idaho 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**	**$9,200 / $18,400**	**$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	40% after deductible	35% after deductible	30% after deductible	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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PacificSource HEALTH PLANS

2025 Idaho Small Group Medical Plans

	Silver HSA 5100**	
	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$5,100 / $10,200**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$5,100 / $10,200**	**$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	0% after deductible	50% after deductible
Telehealth	0% after deductible	50% after deductible
Inpatient Hospital	0% after deductible	50% after deductible
Lab / X-ray	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Emergency Services	0% after deductible	
Chiropractic / Acupuncture 18 visits combined per benefit period	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	0% after deductible	50% after deductible

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	Bronze 6800^	Bronze 9200^	Bronze HSA 8050**	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$6,800 / $13,600**	**$9,200 / $18,400**	**$8,050 / $16,100**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$8,600 / $17,200**	**$9,200 / $18,400**	**$8,050 / $16,100**	**$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 Specialist: $70 after deductible	Primary/Urgent Care: $50 no deductible 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	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	Tier 1: $20 no deductible Tier 2, 3, & 4: 0% after deductible	0% after deductible	50% after deductible

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