



# 2022 Medical Plans for **Idaho Small Groups** | 2–50



# 2022 Idaho | Navigator Small Group Medical Plans

Product	NON-HSA QUALIFIED PLANS																HSA QUALIFIED PLANS**										
	Gold 1000^		Gold 2000^		Silver 3000^		Silver 4500^		Silver 5500^		Silver 6500^		Bronze 6800^		Bronze 8550^		Gold HSA 3000		Silver HSA 3000		Silver HSA 4500		Silver HSA 5500		Bronze HSA 7000		
	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	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
<b>Deductible</b> Individual / Family	\$1,000 / \$2,000	\$10,000 / \$20,000	\$2,000 / \$4,000	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$4,500 / \$9,000	\$10,000 / \$20,000	\$5,500 / \$11,000	\$10,000 / \$20,000	\$6,500 / \$13,000	\$10,000 / \$20,000	\$6,800 / \$13,600	\$10,000 / \$20,000	\$8,550 / \$17,100	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$4,500 / \$9,000	\$10,000 / \$20,000	\$5,500 / \$11,000	\$10,000 / \$20,000	\$7,000 / \$14,000	\$10,000 / \$20,000	
<b>Out-of-Pocket Maximum</b> Individual / Family	\$6,000 / \$12,000	\$15,000 / \$30,000	\$5,500 / \$11,000	\$15,000 / \$30,000	\$8,700 / \$17,400	\$15,000 / \$30,000	\$8,500 / \$17,000	\$15,000 / \$30,000	\$8,000 / \$16,000	\$15,000 / \$30,000	\$7,500 / \$15,000	\$15,000 / \$30,000	\$8,150 / \$16,300	\$15,000 / \$30,000	\$8,550 / \$17,100	\$15,000 / \$30,000	\$3,000 / \$6,000	\$15,000 / \$30,000	\$6,750 / \$13,500	\$15,000 / \$30,000	\$4,500 / \$9,000	\$15,000 / \$30,000	\$5,500 / \$11,000	\$15,000 / \$30,000	\$7,000 / \$14,000	\$15,000 / \$30,000	
	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	NO DEDUCTIBLE, MEMBER PAYS:	AFTER DEDUCTIBLE, MEMBER PAYS:	
<b>Preventive Services</b>	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Preventive Drug Coverage</b>	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Accident Benefit</b>	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.		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.		
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		
<b>Telehealth</b> (including behavioral health for adults)	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Office Visits</b> Primary, Urgent Care, and Specialist	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$25* Specialist: \$60*	50%	Primary/Urgent Care: \$40* Specialist: \$70*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$30* Specialist: \$60*	50%	Primary/Urgent Care: \$35* Specialist: \$60*	50%	Primary/Urgent Care: \$35* Specialist: Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Inpatient Hospital</b>	25%	50%	25%	50%	40%	50%	35%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Lab / X-ray</b>	25%	50%	25%	50%	40%	50%	35%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Physical, Occupational, and Speech Therapy</b> 20 visits per benefit period	\$30*	50%	\$25*	50%	40%	50%	35%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Outpatient Surgery</b>	25%	50%	25%	50%	40%	50%	35%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Emergency Services</b> Copay waived if admitted	\$250 plus 25%	\$250 plus 25%	\$250 plus 25%	\$250 plus 25%	\$250 plus 40%	\$250 plus 40%	\$250 plus 35%	\$250 plus 35%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$500 plus 40%	\$500 plus 40%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	20%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	
<b>Chiropractic / Acupuncture</b> 18 visits combined per benefit period	\$30*	50%	\$25*	50%	\$40*	50%	\$30*	50%	\$30*	50%	\$30*	50%	\$35*	50%	\$35*	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15* Tier 2: \$45* Tier 3 & 4: 20%*	50%	Tier 1: \$10* Tier 2: \$45* Tier 3 & 4: 20%*	50%	Tier 1: \$15* Tier 2: \$90* Tier 3 & 4: 40%*	50%	Tier 1: \$15* Tier 2: \$70* Tier 3 & 4: 35%*	50%	Tier 1: \$15* Tier 2: \$70* Tier 3 & 4: 30%*	50%	Tier 1: \$15* Tier 2: \$70* Tier 3 & 4: 30%*	50%	Tier 1: \$15* Tier 2: \$70* Tier 3 & 4: 30%*	50%	Tier 1: \$20* Tier 2, 3 & 4: Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. ^Adult vision included on this plan. \*Not subject to deductible. \*\*Includes adult vision exams. Benefit 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 [IdahoSales@PacificSource.com](mailto:IdahoSales@PacificSource.com) or go to [PacificSource.com](http://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** or **800-735-3260**.

# Availability Map **by County**

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