PacificSource HEALTH PLANS

2024 Idaho Voyager 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	$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 Tier 2: $15 no deductible Tier 3: $50 no deductible 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 **888-972-9009,** 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 Voyager 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 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 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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PacificSource HEALTH PLANS

2024 Idaho Voyager 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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	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

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	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 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	$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	Tier 1: $20 no deductible Tier 2, 3, & 4: 0% after deductible	0% after deductible	50% after deductible

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