Availability Maps **by County**

More for less from our Navigator products

Navigator is our coordinated care product, where a member's personal provider is navigating care within a coordinated network of health professionals. Navigator promotes better member engagement, self-management, and shared decision making with providers.

Navigator is available for purchase by people living in the following counties: Ada, Adams, Bannock, Bingham, Blaine, Boise, Camas, Canyon, Caribou, Cassia, Custer, Elmore, Gem, Gooding, Jerome, Lemhi, Lincoln, Minidoka, Oneida, Owyhee, Payette, Power, Twin Falls, Valley, and Washington

Freedom to choose with our Voyager products

Voyager products use our preferred provider network, and are suited for members who prefer a more self-directed experience.

Voyager is available for purchase by people living in the following counties: Bear Lake, Benewah, Bonner, Bonneville, Boundary, Butte, Clark, Clearwater, Franklin, Fremont, Idaho, Jefferson, Kootenai, Latah, Lewis, Madison, Nez Perce, Shoshone, and Teton

For more information contact a Coverage Advisor at **(855) 330-2792** or by email at **coverageadvisors@pacificsource.com.**

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PSIP.ID.HMO.0121
PSIP.ID.PPO.0121
PSIP.ID.HMO.CAT.0121

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2021 Medical Plans for **Idaho** Individuals and Families

PacificSource HEALTH PLANS

2021 Idaho | Individual and Family Medical Plans

	NON-HSA QUALIFIED PLANS												HSA QUALIFIED PLANS			
Product	**Gold** 2000		**Gold** 2500		**Silver** 3000		**Silver** 4000		**Bronze** 6000		**Catastrophic^**		**Silver** HSA 3500		**Bronze** HSA 6900	
	Navigator		Navigator or Voyager		Navigator		Navigator		Navigator		Navigator		Navigator or Voyager		Navigator	
	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
Deductible Individual / Family	$2,000 / $4,000	$10,000 / $20,000	$2,500 / $5,000	$10,000 / $20,000	$3,000 / $6,000	$10,000 / $20,000	$4,000 / $8,000	$10,000 / $20,000	$6,000 / $12,000	$10,000 / $20,000	$8,550 / $17,100	$10,000 / $20,000	$3,500 / $7,000	$10,000 / $20,000	$6,900 / $13,800	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$6,000 / $12,000	$85,500 / $171,000	$6,000 / $12,000	$85,500 / $171,000	$8,150 / $16,300	$85,500 / $171,000	$7,900 / $15,800	$85,500 / $171,000	$8,550 / $17,100	$85,500 / $171,000	$8,550 / 17,100	$85,500 / $171,000	$6,750 / $13,500	$85,500 / $171,000	$6,900 / $13,800	$85,500 / $171,000
	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:
Preventive Services	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%
Preventive Drug Coverage	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%
Accident Benefit	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:	
Telemedicine (including behavioral health for adults)	$10*	50%	10%	50%	$10*	50%	$10*	50%	$10*	50%	Visits 1-3 no deductible, covered in full. Visits 4+ covered in full after deductible.	50%	25%	50%	Covered in Full	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $20* Specialist: $40*	50%	10%	50%	Primary/Urgent Care: $35* Specialist: 40%	50%	Primary/Urgent Care: $20* Specialist: $40*	50%	Primary/Urgent Care: $35* Specialist: 50%	50%	Visits 1-3 no deductible, covered in full. Visits 4+ covered in full after deductible. Urgent Care/Specialist: Covered in Full	50%	25%	50%	Covered in Full	50%
Inpatient Hospital	20%	50%	10%	50%	40%	50%	30%	50%	50%	50%	Covered in Full	50%	25%	50%	Covered in Full	50%
Lab / X-ray	20%	50%	10%	50%	40%	50%	30%	50%	50%	50%	Covered in Full	50%	25%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy 20 visits per benefit period	20%	50%	10%	50%	40%	50%	30%	50%	50%	50%	Covered in Full	50%	25%	50%	Covered in Full	50%
Outpatient Surgery	20%	50%	10%	50%	40%	50%	30%	50%	50%	50%	Covered in Full	50%	25%	50%	Covered in Full	50%
Emergency Services	20%	20%	10%	10%	40%	40%	30%	30%	50%	50%	Covered in Full	Covered in Full	25%	25%	Covered in Full	Covered in Full
Chiropractic / Acupuncture 18 combined visits per benefit period	$20*	50%	10%	50%	$35*	50%	$20*	50%	$35*	50%	Covered in Full	50%	25%	50%	Covered in Full	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $15* Tier 2: $60* Tier 3 & 4: 20%*	50%	10%	50%	Tier 1: $15* Tier 2: $60* Tier 3 & 4: 40%*	50%	30%	50%	Tier 1: $25* Tier 2, 3 & 4: 50%	50%	Covered in Full	50%	25%	50%	Covered in Full	50%
Pediatric Eye Exam One exam per benefit period	Covered in Full*	Covered in Full up to $40*	Covered in Full*	Covered in Full up to $40*	Covered in Full*	Covered in Full up to $40*	Covered in Full*	Covered in Full up to $40*	Covered in Full*	Covered in Full up to $40*	Covered in Full	50%	Covered in Full*	Covered in full up to $40*	Covered in Full*	Covered in full up to $40*
Pediatric Vision Hardware One item per benefit period	Covered in full* up to $150 then subject to in-network deductible and 20%		Covered in full* up to $150 then subject to in-network deductible and 10%		Covered in full* up to $150 then subject to in-network deductible and 40%		Covered in full* up to $150 then subject to in-network deductible and 30%		Covered in full* up to $150 then subject to in-network deductible and 50%		Covered in Full	50%	Covered in full* up to $150 then subject to in-network deductible and 25%		Covered in full* up to $150 then subject to in-network deductible	

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. *Not subject to deductible. ^Only available for people under 30, or people of any age with a hardship exemption or affordability exemption. 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 a Coverage Advisor at **(855) 330-2792** or by email at **coverageadvisors@pacificsource.com.** 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 or (800) 735-3260.