Focus on **Vision**

Our vision plans focus on wellness and prevention.

Vision for kids

All of our medical plans include full coverage for in-network pediatric eye exams. Out-of-network eye exams are covered up to $40 with no deductible. After that, member pays 100%. **Pediatric vision hardware is covered in full up to $150.** After that, it's subject to in-network deductible and then a cost-sharing fee up to 50%, depending upon the plan.

Vision for adults

All our non-HSA-qualified plans include coverage for adult eye exams and vision hardware. Please see the Plan Comparison chart for differences among plans.

For more details on our vision benefits, please contact your broker or our team at the contact information listed on the back of this document.

Availability Maps **by County**

More for less from our Navigator products

Navigator is our coordinated care product, where a member's care is navigated 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 businesses domiciled 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 uses our preferred provider network, and is suited for a company culture that prefers a more self-directed experience.

Voyager is available for purchase by businesses domiciled in all Idaho counties.

Contact your broker or our team for a quote. We're happy to help, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Boise: (208) 342-3709 | (888) 492-2875
Coeur d'Alene: (208) 333-1557 | (888) 492-2875
Idaho Falls: (208) 522-1360 | (888) 492-2875
Email: idahosales@pacificsource.com

PacificSource.com

PSGB.ID.SG.Medical.0121
PSGCC.ID.SG.HMO.0121
PSGCC.ID.SG.PPO.0121
PSGCC.ID.SG.HMO.VH.0121
PSGCC.ID.SG.PPO.VH.0121

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2021 Medical Plans for **Idaho** Small Groups | 2–50

PacificSource HEALTH PLANS

2021 Idaho | Small Group Medical Plans

Product	NON-HSA QUALIFIED PLANS															
	Gold 1000^		Gold 2000^		Silver 3000^		Silver 4500^		Silver 5500^		Silver 6500^		Bronze 6800^		Bronze 8550^	
	Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager	
	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	$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
Out-of-Pocket Maximum Individual / Family	$6,000 / $12,000	$15,000 / $30,000	$5,500 / $11,000	$15,000 / $30,000	$8,150 / $16,300	$15,000 / $30,000	$8,000 / $16,000	$15,000 / $30,000	$7,500 / $15,000	$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
	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%	$10*	50%	$10*	50%	$10*	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $25* Specialist: $60*	50%	Primary/Urgent Care: $25* Specialist: $60*	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: $30* Specialist: $60*	50%	Primary/Urgent Care: $35* Specialist: 40%	50%	Primary/Urgent Care: $35* Specialist: Covered in Full	50%
Inpatient Hospital	25%	50%	25%	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%
Lab / X-ray	25%	50%	25%	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy 20 visits per benefit period	$25*	50%	$25*	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%
Outpatient Surgery	25%	50%	25%	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%
Emergency Services Copay waived if admitted	$250 plus 25%	$250 plus 25%	$250 plus 25%	$250 plus 25%	$250 plus 40%	$250 plus 40%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$500 plus 40%	$500 plus 40%	Covered in Full	Covered in Full
Chiropractic / Acupuncture 18 visits combined per benefit period	$25*	50%	$25*	50%	$30*	50%	$30*	50%	$30*	50%	$30*	50%	$35*	50%	$35*	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $10* 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: 30%*	50%	Tier 1: $15* Tier 2: $70* Tier 3 & 4: 30%*	50%	Tier 1: $15* Tier 2: $70* Tier 3 & 4: 30%*	50%	40%	50%	Tier 1: $20* Tier 2, 3 & 4: Covered in Full	50%

Product	HSA QUALIFIED PLANS**									
	Gold HSA 3000		Silver HSA 3000		Silver HSA 4500		Silver HSA 5500		Bronze HSA 6900	
	Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager		Navigator or Voyager	
	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	$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	$6,900 / $13,800	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$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	$6,900 / $13,800	$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:
Preventive Services	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%
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.	
	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)	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Office Visits Primary, Urgent Care, and Specialist	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Inpatient Hospital	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Lab / X-ray	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy 20 visits per benefit period	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Outpatient Surgery	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Emergency Services Copay waived if admitted	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
Chiropractic / Acupuncture 18 visits combined per benefit period	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	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** 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 or (800) 735-3260.