PacificSource HEALTH PLANS

VOYAGER

2023 Medical Plans for
Idaho Individuals and Families

2023 Idaho | Voyager Individual and Family Medical Plans

	Gold 2500		Silver 3600		Bronze 6000		Bronze 9100		Catastrophic^		HSA-QUALIFIED PLANS: Silver HSA 3500		HSA-QUALIFIED PLANS: Bronze HSA 7050	
	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	$2,500 / $5,000	$10,000 / $20,000	$3,600 / $7,200	$10,000 / $20,000	$6,000 / $12,000	$10,000 / $20,000	$9,100 / $18,200	$10,000 / $20,000	$9,100 / $18,200	$10,000 / $20,000	$3,500 / $7,000	$10,000 / $20,000	$7,050 / $14,100	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$6,000 / $12,000	$85,500 / $171,000	$9,100 / $18,200	$85,500 / $171,000	$8,550 / $17,100	$85,500 / $171,000	$9,100 / $18,200	$85,500 / $171,000	$9,100 / $18,200	$85,500 / $171,000	$6,700 / $13,400	$85,500 / $171,000	$7,050 / $14,100	$85,500 / $171,000
Preventive Services	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	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	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	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		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	
Office Visits **Primary, Urgent Care, and Specialist (includes behavioral health)**	Primary/Urgent Care: $25 no deductible Specialist: $50 no deductible	50% after deductible	Primary/Urgent Care: $35 no deductible Specialist: $70 after deductible	50% after deductible	Primary/Urgent Care: $35 no deductible Specialist: $70 after deductible	50% after deductible	Primary/Urgent Care: $40 no deductible Specialist: $80 no deductible	50% after deductible	Visits 1-3 no deductible, covered in full Visits 4+ covered in full after deductible Urgent Care/Specialist: Covered in full after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Telehealth	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Visits 1-3 no deductible, covered in full Visits 4+ covered in full after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Inpatient Hospital Stay	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Lab / X-ray	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy 20 visits per benefit period	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible	40% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Emergency Services	10% after deductible	10% after deductible	40% after deductible	40% after deductible	50% after deductible	50% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	25% after deductible	25% after deductible	0% after deductible	0% after deductible
Chiropractic / Acupuncture 18 combined visits per benefit period	$25 no deductible	50% after deductible	$35 no deductible	50% after deductible	$35 no deductible	50% after deductible	$40 no deductible	50% after deductible	0% after deductible	50% after deductible	25% after 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: $60 no deductible Tier 3 & 4: 10% no deductible	50% after deductible	Tier 1: $15 no deductible Tier 2: $60 no deductible Tier 3 & 4: 40% no deductible	50% after deductible	Tier 1: $25 no deductible Tier 2, 3, & 4: 50% after deductible	50% after deductible	Tier 1: $20 no deductible Tier 2, 3, & 4: 0% after deductible	50% after deductible	0% after deductible	50% after deductible	25% after deductible	50% after deductible	0% after deductible	50% after deductible
Pediatric Eye Exam	Covered in full	Covered in full up to $40 no deductible	Covered in full	Covered in full up to $40 no deductible	Covered in full	Covered in full up to $40 no deductible	Covered in full	Covered in full up to $40 no deductible	0% after deductible	50% after deductible	Covered in full	Covered in full up to $40 no deductible	Covered in full	Covered in full up to $40 no deductible
Pediatric Vision Hardware	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 50%		Covered in full up to $150 then subject to in-network deductible		0% after deductible	50% after deductible	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	

^Only available for people under 30, or people of any age with a hardship exemption or affordability exemption.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. 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 **855-330-2792,** TTY: 711. We accept all relay calls.

Availability map **by county**

Statewide access with our Voyager products

Voyager features our statewide network of healthcare professionals and facilities—the doctors and hospitals you want. Out-of-network benefits are also available, for freedom and choice.

Voyager is available for purchase by people living in the following counties: Benewah, Bonner, Boundary, Clearwater, Idaho, Kootenai, Latah, Lewis, Nez Perce, and Shoshone

For more information, contact a Coverage Advisor at **855-839-2975,** TTY: 711 (we accept all relay calls), or by email at CoverageAdvisors@PacificSource.com.