

# 2024 Idaho Voyager Large Group Medical Plans

	1000+30_20 1000+30_30		1500+30_20 1500+30_30		2000+30_20 2000+30_30		2500+30_20 2500+30_30	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$1,000 / \$2,000	\$2,000 / \$4,000	\$1,500 / \$3,000	\$3,000 / \$6,000	\$2,000 / \$4,000	\$4,000 / \$8,000	\$2,500 / \$5,000	\$5,000 / \$10,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$4,000 / \$8,000	\$8,000 / \$16,000	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$5,000 / \$10,000	\$10,000 / \$20,000
	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>
<b>Preventive Services</b>	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>
<b>Telehealth</b>	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%
<b>Office Visits: Primary</b> (including behavioral health), <b>Urgent Care, and Specialist</b>	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%
<b>Inpatient Hospital</b>	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
<b>Lab / X-ray</b>	No deductible up to \$400, then after deductible 20% or 30%	50%	No deductible up to \$400, then after deductible 20% or 30%	50%	No deductible up to \$400, then after deductible 20% or 30%	50%	No deductible up to \$400, then after deductible 20% or 30%	50%
<b>Physical, Occupational, and Speech Therapy</b> 30 visits per benefit period	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
<b>Chiropractic / Acupuncture</b> 18 visits combined per benefit period	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%
<b>Outpatient Surgery</b>	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
<b>Emergency Services</b> Copay waived if admitted	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%
<b>Prescription (Rx) Drug Coverage</b>	For prescription drug coverage, choose from two no-deductible options on copay-style plans. One option offers copays on all four tiers; a second option offers copays on Tiers 1 & 2, and 20% coinsurance on Tiers 3 & 4.							

\*Not subject to deductible.

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. This is a brief summary. Contact us at **888-533-6066**, [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 table or the rest of the document, please call us at 888-977-9299, TTY: 711. We accept all relay calls.

# 2024 Idaho Voyager Large Group Medical Plans

	3000+30_20 3000+30_30		4000+30_20 4000+30_30		5000+30_20 5000+30_30		7000+30_20 7000+30_30	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$3,000 / \$6,000	\$6,000 / \$12,000	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$7,000 / \$14,000	\$14,000 / \$28,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$5,000 / \$10,000	\$10,000 / \$20,000	\$6,000 / \$12,000	\$12,000 / \$24,000	\$6,850 / \$13,700	\$13,700 / \$27,400	\$8,550 / \$17,100	\$17,100 / \$34,200
	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>
<b>Preventive Services</b>	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>		<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>		<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>		<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	
<b>Telehealth</b>	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%
<b>Office Visits: Primary</b> (including behavioral health), <b>Urgent Care, and Specialist</b>	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%
<b>Inpatient Hospital</b>	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
<b>Lab / X-ray</b>	No deductible up to \$400, then after deductible 20% or 30%	50%	No deductible up to \$400, then after deductible 20% or 30%	50%	No deductible up to \$400, then after deductible 20% or 30%	50%	No deductible up to \$400, then after deductible 20% or 30%	50%
<b>Physical, Occupational, and Speech Therapy</b> 30 visits per benefit period	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
<b>Chiropractic / Acupuncture</b> 18 visits combined per benefit period	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%
<b>Outpatient Surgery</b>	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
<b>Emergency Services</b> Copay waived if admitted	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%	\$100 plus 20% or 30%
<b>Prescription (Rx) Drug Coverage</b>	For prescription drug coverage, choose from two no-deductible options on copay-style plans. One option offers copays on all four tiers; a second option offers copays on Tiers 1 & 2, and 20% coinsurance on Tiers 3 & 4.							

\*Not subject to deductible.

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# 2024 Idaho Voyager Large Group Medical Plans

	HSA 1600_20+Rx Non-Embedded		HSA 3200_20+Rx		HSA 3200_50+Rx		HSA 3200+Rx	
	IN NETWORK	OUT OF NETWORK						
<b>Deductible</b> Individual / Family	\$1,600 / \$3,200	\$3,000 / \$6,000	\$3,200 / \$6,400	\$3,200 / \$6,400	\$3,200 / \$6,400	\$6,000 / \$12,000	\$3,200 / \$6,400	\$6,000 / \$12,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$4,500 / \$6,850	\$9,000 / \$13,700	\$5,000 / \$10,000	\$10,000 / \$20,000	\$6,350 / \$12,700	\$12,700 / \$25,400	\$3,200 / \$6,400	\$12,000 / \$24,000
	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>						
<b>Preventive Services</b>	Covered in full	75%	Covered in full	50%	Covered in full	75%	Covered in full	75%
	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>
<b>Telehealth</b>	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Office Visits: Primary</b> (including behavioral health), <b>Urgent Care, and Specialist</b>	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Inpatient Hospital</b>	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Lab / X-ray</b>	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Physical, Occupational, and Speech Therapy</b> 30 visits per benefit period	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Chiropractic / Acupuncture</b> 18 visits combined per benefit period	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Outpatient Surgery</b>	20%	75%	20%	50%	50%	75%	Covered in full	75%
<b>Emergency Services</b> Copay waived if admitted	20%	20%	20%	20%	50%	50%	Covered in full	Covered in full
<b>Prescription (Rx) Drug Coverage</b>	Covered in full	90%						

\*Not subject to deductible.

Plans are available to businesses statewide.

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# 2024 Idaho Voyager Large Group Medical Plans

	HSA 4000+Rx		HSA 5000+Rx		HSA 7000+Rx	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
<b>Deductible</b> Individual / Family	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$7,000 / \$14,000	\$24,000 / \$48,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$4,000 / \$8,000	\$16,000 / \$32,000	\$5,000 / \$10,000	\$20,000 / \$40,000	\$7,000 / \$14,000	\$48,000 / \$96,000
	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	<b>NO DEDUCTIBLE, MEMBER PAYS:</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>
<b>Preventive Services</b>	Covered in full	75%	Covered in full	75%	Covered in full	75%
	<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>		<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>		<b>AFTER DEDUCTIBLE, MEMBER PAYS:</b>	
<b>Telehealth</b>	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Office Visits: Primary</b> (including behavioral health), <b>Urgent Care, and Specialist</b>	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Inpatient Hospital</b>	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Lab / X-ray</b>	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Physical, Occupational, and Speech Therapy</b> 30 visits per benefit period	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Chiropractic / Acupuncture</b> 18 visits combined per benefit period	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Outpatient Surgery</b>	Covered in full	75%	Covered in full	75%	Covered in full	75%
<b>Emergency Services</b> Copay waived if admitted	Covered in full					
<b>Prescription (Rx) Drug Coverage</b>	Covered in full	90%	Covered in full	90%	Covered in full	90%

\*Not subject to deductible.

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