PacificSource HEALTH PLANS

2025 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
Deductible 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**
Out-of-Pocket Maximum 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**
	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%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	$30*	50%	$30*	50%	$30*	50%	$30*	50%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	$30*	50%	$30*	50%	$30*	50%	$30*	50%
Inpatient Hospital	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
Lab / X-ray	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%
Physical, Occupational, and Speech Therapy 30 visits per benefit period	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
Chiropractic / Acupuncture 18 visits combined per benefit period	$30*	50%	$30*	50%	$30*	50%	$30*	50%
Outpatient Surgery	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
Emergency Services 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%
Prescription (Rx) Drug Coverage	For prescription drug coverage, choose from two no-deductible copay-style plan option. 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, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
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2025 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
Deductible 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**
Out-of-Pocket Maximum 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**
	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%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	$30*	50%	$30*	50%	$30*	50%	$30*	50%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	$30*	50%	$30*	50%	$30*	50%	$30*	50%
Inpatient Hospital	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
Lab / X-ray	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%
Physical, Occupational, and Speech Therapy 30 visits per benefit period	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
Chiropractic / Acupuncture 18 visits combined per benefit period	$30*	50%	$30*	50%	$30*	50%	$30*	50%
Outpatient Surgery	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%	20% or 30%	50%
Emergency Services 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%
Prescription (Rx) Drug Coverage	For prescription drug coverage, choose from two no-deductible copay-style plan options. 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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2025 Idaho Voyager Large Group Medical Plans

	HSA 1650_20+Rx Non-Embedded		HSA 3300_20+Rx		HSA 3300_50+Rx		HSA 3300+Rx	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	$1,650 / $3,300	$3,000 / $6,000	$3,300 / $6,600	$3,300 / $6,600	$3,300 / $6,600	$6,000 / $12,000	$3,300 / $6,600	$6,000 / $12,000
Out-of-Pocket Maximum 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	$3,300 / $6,600	$12,000 / $24,000
	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:
Preventive Services	Covered in full	75%	Covered in full	50%	Covered in full	75%	Covered in full	75%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	20%	75%	20%	50%	50%	75%	Covered in full	75%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	20%	75%	20%	50%	50%	75%	Covered in full	75%
Inpatient Hospital	20%	75%	20%	50%	50%	75%	Covered in full	75%
Lab / X-ray	20%	75%	20%	50%	50%	75%	Covered in full	75%
Physical, Occupational, and Speech Therapy 30 visits per benefit period	20%	75%	20%	50%	50%	75%	Covered in full	75%
Chiropractic / Acupuncture 18 visits combined per benefit period	20%	75%	20%	50%	50%	75%	Covered in full	75%
Outpatient Surgery	20%	75%	20%	50%	50%	75%	Covered in full	75%
Emergency Services Copay waived if admitted	20%	20%	20%	20%	50%	50%	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	20%	90%	20%	90%	50%	90%	Covered in full	90%

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	HSA 4000+Rx		HSA 5000+Rx		HSA 7000+Rx	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible 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
Out-of-Pocket Maximum 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
	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	75%	Covered in full	75%	Covered in full	75%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telehealth	Covered in full	75%	Covered in full	75%	Covered in full	75%
Office Visits: Primary (including behavioral health), **Urgent Care, and Specialist**	Covered in full	75%	Covered in full	75%	Covered in full	75%
Inpatient Hospital	Covered in full	75%	Covered in full	75%	Covered in full	75%
Lab / X-ray	Covered in full	75%	Covered in full	75%	Covered in full	75%
Physical, Occupational, and Speech Therapy 30 visits per benefit period	Covered in full	75%	Covered in full	75%	Covered in full	75%
Chiropractic / Acupuncture 18 visits combined per benefit period	Covered in full	75%	Covered in full	75%	Covered in full	75%
Outpatient Surgery	Covered in full	75%	Covered in full	75%	Covered in full	75%
Emergency Services Copay waived if admitted	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	Covered in full	90%	Covered in full	90%	Covered in full	90%

*Not subject to deductible.

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