PacificSource HEALTH PLANS

2024 Washington Voyager Small Group Medical Plans

	Platinum 500 PD^	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$5,000 / $10,000**
Out-of-Pocket Maximum Individual / Family	**$3,000 / $6,000**	**$7,500 / $15,000**
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $10 no deductible Specialist: $20 no deductible	50% after deductible
Telehealth	$10 no deductible	50% after deductible
Inpatient Hospital	10% after deductible	50% after deductible
Lab / X-ray	10% no deductible	50% after deductible
Physical, Occupational, and Speech Therapy	$10 no deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Emergency Services	$250 plus 10% after deductible	
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$10 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $5 no deductible Tier 2: $15 no deductible Tier 3 & 4: 20% no deductible	90% after deductible

^Adult vision included on this plan.

Plans are available to businesses statewide.

Pediatric dental coverage is included with all of these plans.

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 **888-672-3123,** WashingtonSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.

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PacificSource HEALTH PLANS

2024 Washington Voyager Small Group Medical Plans

	Gold 1000 PD^	Gold 1500 PD^	Gold 2000 PD^	Gold 2500 PD^	Gold 3500 PD^	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$1,000 / $2,000**	**$1,500 / $3,000**	**$2,000 / $4,000**	**$2,500 / $5,000**	**$3,500 / $7,000**	**$5,000 / $10,000**
Out-of-Pocket Maximum Individual / Family	**$7,900 / $15,800**	**$7,900 / $15,800**	**$7,900 / $15,800**	**$7,900 / $15,800**	**$7,900 / $15,800**	**$8,000 / $16,000**
Preventive Services	Covered in full					50% after deductible
Preventive Drug Coverage	Covered in full					90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $25 no deductible Specialist: $60 no deductible					50% after deductible
Telehealth	$25 no deductible					50% after deductible
Inpatient Hospital	25% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	50% after deductible
Lab / X-ray	25% no deductible	20% no deductible	20% no deductible	20% no deductible	20% no deductible	50% after deductible
Physical, Occupational, and Speech Therapy	$25 no deductible					50% after deductible
Outpatient Surgery	25% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	50% after deductible
Emergency Services	$250 plus 25% after deductible	$250 plus 20% after deductible	$250 plus 20% after deductible	$250 plus 20% after deductible	$250 plus 20% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$25 no 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: 30% no deductible					90% after deductible

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PacificSource HEALTH PLANS

2024 Washington Voyager Small Group Medical Plans

	Gold HSA 3200 PD	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$3,200 / $6,400	$5,000 / $10,000
Out-of-Pocket Maximum Individual / Family	$3,200 / $6,400	$7,500 / $15,000
Preventive Services	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	0% after deductible	50% after deductible
Telehealth	0% after deductible	50% after deductible
Inpatient Hospital	0% after deductible	50% after deductible
Lab / X-ray	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Emergency Services	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	0% after deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	0% after deductible	90% after deductible

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PacificSource HEALTH PLANS

2024 Washington Voyager Small Group Medical Plans

	Silver 3000 PD	Silver 4500 PD^	Silver 5500 PD^	Silver 6500 PD^	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,000 / $6,000**	**$4,500 / $9,000**	**$5,500 / $11,000**	**$6,500 / $13,000**	Silver 3000 & 6500: **$10,000 / $20,000** Silver 4500 & 5500: **$7,500 / $15,000**
Out-of-Pocket Maximum Individual / Family	**$9,100 / $18,200**	**$9,100 / $18,200**	**$9,100 / $18,200**	**$9,100 / $18,200**	Silver 3000 & 6500: **$15,000 / $30,000** Silver 4500 & 5500: **$11,250 / $22,500**
Preventive Services	Covered in full				50% after deductible
Preventive Drug Coverage	Covered in full				90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $50 no deductible Specialist: $100 no deductible				50% after deductible
Telehealth	$50 no deductible				50% after deductible
Inpatient Hospital	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Lab / X-ray	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	35% after deductible	30% after deductible	30% after deductible	50% after deductible
Emergency Services	40% after deductible	$250 plus 35% after deductible	$250 plus 30% after deductible	$250 plus 30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	40% after deductible	$50 no deductible	$50 no deductible	$50 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $20 no deductible Tier 2: $60 no deductible Tier 3 & 4: 40% no deductible	Tier 1: $20 no deductible Tier 2: $60 no deductible Tier 3 & 4: 35% no deductible	Tier 1: $20 no deductible Tier 2: $60 no deductible Tier 3 & 4: 30% no deductible	Tier 1: $20 no deductible Tier 2: $60 no deductible Tier 3 & 4: 30% no deductible	90% after deductible

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PacificSource HEALTH PLANS

2024 Washington Voyager Small Group Medical Plans

	Silver HSA 3200 PD	Silver HSA 5100 PD	Silver HSA 5500 PD	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,200 / $6,400**	**$5,100 / $10,200**	**$5,500 / $11,000**	Silver HSA 3200: **$5,000 / $10,000** Silver HSA 5100 & 5500: **$7,500 / $15,000**
Out-of-Pocket Maximum Individual / Family	**$7,750 / $15,500**	**$5,100 / $10,200**	**$5,500 / $11,000**	Silver HSA 3200: **$10,000 / $20,000** Silver HSA 5100 & 5500: **$11,250 / $22,500**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	20% after deductible	0% after deductible	0% after deductible	50% after deductible
Telehealth	20% after deductible	0% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	20% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	20% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	20% after deductible	0% 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	20% after deductible	0% after deductible	0% after deductible	90% after deductible

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PacificSource HEALTH PLANS

2024 Washington Voyager Small Group Medical Plans

	Bronze 8700 PD	Bronze HSA 6000 PD	Bronze HSA 7500 PD	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$8,700 / $17,400**	**$6,000 / $12,000**	**$7,500 / $15,000**	Bronze HSA 6000: **$7,500 / $15,000** Bronze 8700 & HSA 7500: **$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$8,700 / $17,400**	**$7,200 / $14,400**	**$7,500 / $15,000**	Bronze HSA 6000: **$11,250 / $22,500** Bronze 8700 & HSA 7500: **$15,000 / $30,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Office Visits: Primary, Urgent Care, and Specialist	Primary/Urgent: $50 no deductible Specialist: $100 no deductible	50% after deductible	0% after deductible	50% after deductible
Telehealth	$50 no deductible	50% after deductible	0% after deductible	50% after deductible
Inpatient Hospital	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Lab / X-ray	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Emergency Services	0% after deductible	50% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	0% 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	0% after deductible	50% after deductible	0% after deductible	90% after deductible

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