PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Gold 500 Direct†	Gold 1500 Direct†	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$1,500 / $3,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$8,250 / $16,500**	**$7,500 / $15,000**	**$25,000 / $50,000**
Preventive Services	Covered in full		50% after deductible
Preventive Drug Coverage	Covered in full		90% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident		
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+ and Urgent Care: $25 no deductible Specialist: $50 no deductible		50% after deductible
Telehealth			50% after deductible
Inpatient Hospital	30% after deductible	20% after deductible	50% after deductible
Lab / X-ray	30% after deductible	20% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	20% after deductible	50% after deductible
Emergency Services	30% after deductible	20% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / 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: $25 no deductible Tier 2: $50 no deductible Tier 3 & 4: 30% no deductible	Tier 1: $25 no deductible Tier 2: $50 no deductible Tier 3 & 4: 20% no deductible	90% after deductible
Pediatric Eye Exam	Covered in full		Covered in full up to $40
Pediatric Vision Hardware	Covered in full up to $150 then subject to in-network deductible and 30%	Covered in full up to $150 then subject to in-network deductible and 20%	Same as in-network

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†Adult vision included on this plan.

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing.

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Silver 3400 Direct	Silver 3900 Direct	Silver 5400 Direct	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,400 / $6,800**	**$3,900 / $7,800**	**$5,400 / $10,800**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,100 / $18,200**	**$9,400 / $18,800**	**$25,000 / $50,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary and Urgent Care: $50 no deductible Specialist: $100 no deductible	Primary and Urgent Care: $30 no deductible Specialist: $60 no deductible	Primary: $40 no deductible Urgent Care: $70 no deductible Specialist: $80 no deductible	50% after deductible
Telehealth	$50 no deductible	$30 no deductible	$40 no deductible	50% after deductible
Inpatient Hospital	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Lab / X-ray	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	50% after deductible	30% after deductible	$40 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	50% after deductible	30% after deductible	30% after deductible	50% after deductible
Emergency Services	50% after deductible	30% after deductible	30% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no deductible	$30 no deductible	$40 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: $50 no deductible Tier 3 & 4: 50% no deductible	30% after deductible	Tier 1: $20 no deductible Tier 2: $50 no deductible Tier 3 & 4: 50% no deductible	90% after deductible
Pediatric Eye Exam	Covered in full			Covered in full up to $40
Pediatric Vision Hardware	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 and 30%	Covered in full up to $150 then subject to in-network deductible and 30%	Same as in-network

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Bronze 7000 Direct	Bronze 9400 Direct	Bronze HSA 7500	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$7,000 / $14,000**	**$9,400 / $18,800**	**$7,500 / $15,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,400 / $18,800**	**$7,500 / $15,000**	**$25,000 / $50,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% after deductible
Accident Benefit	Covered in full up to $500, within 90 days of accident			
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+ and Urgent Care: $50 no deductible Specialist: $100 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: 0% after deductible Urgent Care/Specialist: 0% after deductible	0% after deductible	50% after deductible
Telehealth			0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no 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	40% after deductible	0% after deductible	0% after deductible	90% after deductible
Pediatric Eye Exam	Covered in full			Covered in full up to $40
Pediatric Vision Hardware	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	Covered in full up to $150 then subject to in-network deductible	Same as in-network

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PacificSource HEALTH PLANS

2024 Oregon Navigator Individual and Family Medical Plans

	Standard Gold	Standard Silver	Standard Bronze	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$1,800 / $3,600**	**$5,500 / $11,000**	**9,450 / $18,900**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$7,550 / $15,100**	**$9,450 / $18,900**	**9,450 / $18,900**	**$25,000 / $50,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			50% after deductible
Accident Benefit	Not covered			
Office Visits: Primary, Urgent Care, and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $20 no deductible Urgent Care: $60 no deductible Specialist: $40 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $40 no deductible Urgent Care: $70 no deductible Specialist: $80 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $50 no deductible Urgent Care: $100 no deductible Specialist: $150 no deductible	50% after deductible
Telehealth				50% after deductible
Inpatient Hospital	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Lab / X-ray	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$20 no deductible if provided in an office setting	$40 no deductible if provided in an office setting	$50 no deductible if provided in an office setting	50% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	0% after deductible	50% after deductible
Emergency Services	20% after deductible	30% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$20 no deductible	$40 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: $10 no deductible Tier 2: $30 no deductible Tier 3: 50% Coinsurance no deductible Tier 4: 50% Coinsurance no deductible, $500 max/script	Tier 1: $15 no deductible Tier 2: $60 no deductible Tier 3 & 4: 50% Coinsurance no deductible	Tier 1: $25 no deductible Tier 2, 3, & 4: 0% after deductible	90% after deductible
Pediatric Eye Exam One exam per benefit period	Covered in full			Covered in full up to $40
Pediatric Vision Hardware One item per benefit period	Covered in full up to $150 then subject to in-network deductible and 20%	Covered in full up to $150 then subject to in-network deductible and 30%	Covered in full up to $150 then subject to in-network deductible	Same as in-network

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