

2024 Oregon Navigator Individual and Family Medical Plans

	Gold 500 Exchange [†]	Gold 1500 Exchange [†]	
	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 and Urgent Care: \$25 no deductible Specialist: \$50 no deductible		50% after deductible
Telehealth	\$25 no deductible	\$25 no deductible	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

Plans are available to residents statewide, but please check PacificSource.com/Find-a-Doctor to ensure your provider is in-network.

[†]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.

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.

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	Silver 3500 Exchange	Silver 4000 Exchange	
	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$3,500 / \$7,000	\$4,000 / \$8,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$9,400 / \$18,800	\$9,100 / \$18,200	\$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	50% after deductible
Telehealth	\$50 no deductible	\$30 no deductible	50% after deductible
Inpatient Hospital	50% after deductible	30% after deductible	50% after deductible
Lab / X-ray	50% after deductible	30% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	50% after deductible	30% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	30% after deductible	50% after deductible
Emergency Services	50% 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	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	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%	Same as in-network

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	Bronze 7000 Exchange	Bronze 9400 Exchange	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 and Urgent Care: \$50 no deductible Specialist: \$100 no deductible	0% after deductible	0% after deductible	50% after deductible
Telehealth	\$50 no deductible	0% after deductible	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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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 Primary visits 4+: \$20, no deductible Urgent Care: \$60 no deductible Specialist: \$40 no deductible	Primary/telehealth combined visits 1-3: \$5, no deductible Primary visits 4+: \$40 no deductible Urgent Care: \$70 no deductible Specialist: \$80 no deductible	Primary/telehealth combined visits 1-3: \$5, no deductible Primary 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% no deductible Tier 4: 50% no deductible \$500 max/script	Tier 1: \$15 no deductible Tier 2: \$60 no deductible Tier 3 & 4: 50% 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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