

Availability Maps **by County**



More for less from our **Navigator** products

Navigator is our clinically integrated product, where a member's personal provider is navigating care within a coordinated network of health professionals. Navigator promotes better member engagement and shared decision making with providers.

Navigator gives access to a broad array of in-network providers, including local providers, providers within our four-state area, and those available for urgent and emergent conditions while traveling nationally through contracts with First Health®, and in Alaska through contracts with First Choice Health™. Navigator products also offer out-of-network benefits, for more freedom and choice.

Navigator is available for purchase by people living in the following counties: Clark, Pierce, and Spokane

For more information contact a Coverage Advisor at **(855) 330-2792**
or by email at **coverageadvisors@pacificsource.com**.

PacificSource.com



2020 Medical Plans for **Washington** Individuals and Families



2020 Washington | Individual and Family Medical Plans

	NON-HSA QUALIFIED PLANS										HSA QUALIFIED PLANS	
Product	Gold 1500		Silver 3500 [†]		Silver 5000		Bronze 7000		Catastrophic [^]		Bronze HSA 6750	
	Navigator		Navigator		Navigator		Navigator		Navigator		Navigator	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$1,500 / \$3,000	\$10,000 / \$20,000	\$3,500 / \$7,000	\$10,000 / \$20,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$7,000 / \$14,000	\$10,000 / \$20,000	\$8,150 / \$16,300	\$10,000 / \$20,000	\$6,750 / \$13,500	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$5,000 / \$10,000	\$25,000 / \$50,000	\$7,500 / \$15,000	\$25,000 / \$50,000	\$8,150 / \$16,300	\$25,000 / \$50,000	\$8,150 / \$16,300	\$25,000 / \$50,000	\$8,150 / \$16,300	\$25,000 / \$50,000	\$6,750 / \$13,500	\$25,000 / \$50,000
	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:	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%	Covered in Full	50%	Covered in Full	50%
Preventive Drug Coverage	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telemedicine (including behavioral health for adults)	\$10*	50%	\$10*	50%	\$10*	50%	\$10*	50%	Telemedicine and office combined visits 1-3 no deductible, covered in full. Visits 4+ covered in full after deductible.	50%	Covered in Full	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: \$20* Specialist: \$40*	50%	Primary/Urgent Care: \$40* Specialist: 30%	50%	Primary/Urgent Care: \$35* Specialist: \$70*	50%	Primary/Urgent Care: \$35* Specialist: 40%	50%	Telemedicine and office combined visits 1-3 no deductible, covered in full. Visits 4+ covered in full after deductible. Urgent Care/ Specialist: Covered in Full	50%	Covered in Full	50%
Inpatient Hospital	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%
Lab / X-ray	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy 25 visits per benefit period	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%
Outpatient Surgery	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%
Emergency Services	20%	20%	30%	30%	30%	30%	40%	40%	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	\$20*	50%	\$40*	50%	\$35*	50%	\$35*	50%	Covered in Full	50%	Covered in Full	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15* Tier 2: \$70* Tier 3 & 4: 20%*	90%	Tier 1: \$15* Tier 2: \$80* Tier 3 & 4: 30%*	90%	30%	90%	40%	90%	Covered in Full	90%	Covered in Full	90%
Pediatric Eye Exam One exam per benefit period	Covered in Full*	Covered in Full up to \$40*	Covered in Full*	Covered in Full up to \$40*	Covered in Full*	Covered in Full up to \$40*	Covered in Full*	Covered in Full up to \$40*	Covered in Full	50%	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 and 30%		Covered in full* up to \$150 then subject to in-network deductible and 40%		Covered in Full	50%	Covered in full* up to \$150 then subject to in-network deductible	

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. * Not subject to deductible. ^ Only available for people under 30, or people of any age with a hardship exemption or affordability exemption. † Only available on a direct basis. 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.