PacificSource HEALTH PLANS

2024 Oregon Voyager Small Group Medical Plans

	Platinum 500^	
	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$5,000 / $10,000**
Out-of-Pocket Maximum Individual / Family	**$4,000 / $8,000**	**$7,500 / $15,000**
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+ $10 no deductible Urgent: $10 no deductible Specialist: $20 no deductible	50% after deductible
Telehealth		50% after deductible
Inpatient Hospital	20% after deductible	50% after deductible
Lab / X-ray	20% no deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$10 no deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Services	$250 plus 20% after deductible	
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / 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 in Baker, Jackson, Josephine, and Malheur Counties.

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 Voyager Small Group Medical Plans

	Gold 1000^	Gold 2000^	Gold 2500^	Gold 3500^	Gold HSA 3200	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$1,000 / $2,000	$2,000 / $4,000	$2,500 / $5,000	$3,500 / $7,000	$3,200 / $6,400	$5,000 / $10,000
Out-of-Pocket Maximum Individual / Family	$7,000 / $14,000	$6,500 / $13,000	$6,500 / $13,000	$6,500 / $13,000	$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
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+: $25 no deductible Urgent: $25 no deductible Specialist: $75 no deductible				0% after deductible	50% after deductible
Telehealth					0% after deductible	50% after deductible
Inpatient Hospital	30% after deductible				0% after deductible	50% after deductible
Lab / X-ray	30% no deductible				0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$25 no deductible				0% after deductible	50% after deductible
Outpatient Surgery	30% after deductible				0% after deductible	50% after deductible
Emergency Services	$250 plus 30% after deductible				0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$25 no deductible				0% after 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: $45 no deductible Tier 3 & 4: 30% no deductible				0% after deductible	90% after deductible

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PacificSource HEALTH PLANS

2024 Oregon Voyager Small Group Medical Plans

	Silver 3500	Silver 4500^	Silver 5000^	Silver 5500^	Silver 6500^	
	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$4,500 / $9,000**	**$5,000 / $10,000**	**$5,500 / $11,000**	**$6,500 / $13,000**	Silver 3500, 6500: **$10,000 / $20,000** Silver 4500, 5000, 5500: **$7,500 / $15,000**
Out-of-Pocket Maximum Individual / Family	**$9,400 / $18,800**	**$9,400 / $18,800**	**$9,400 / $18,800**	**$9,400 / $18,800**	**$9,400 / $18,800**	Silver 3500, 6500: **$15,000 / $30,000** Silver 4500, 5000, 5500: **$11,250 / $22,500**
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+: $50 no deductible Urgent: $50 no deductible Specialist: $100 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $40 no deductible Urgent: $40 no deductible Specialist: $100 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $40 no deductible Urgent: $40 no deductible Specialist: $80 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $35 no deductible Urgent: $35 no deductible Specialist: $70 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $35 no deductible Urgent: $35 no deductible Specialist: $70 no deductible	50% after deductible
Telehealth						50% after deductible
Inpatient Hospital	50% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
Lab / X-ray	50% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	50% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
Emergency Services	50% after deductible	$250 plus 40% after deductible	$250 plus 50% after deductible	$250 plus 40% after deductible	$250 plus 35% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$50 no deductible	$40 no deductible	$40 no deductible	$35 no deductible	$35 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	Tier 1: $20 no deductible Tier 2: $50 no deductible Tier 3 & 4: 40% no deductible	Tier 1: $10 no deductible Tier 2, 3, & 4: 50% no deductible	Tier 1: $20 no deductible Tier 2: $50 no deductible Tier 3 & 4: 40% no deductible	Tier 1: $20 no deductible Tier 2: $50 no deductible Tier 3 & 4: 35% no deductible	90% after deductible

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PacificSource HEALTH PLANS

2024 Oregon Voyager Small Group Medical Plans

	Silver HSA 3500	Silver HSA 5100	Silver HSA 5500	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$5,100 / $10,200**	**$5,500 / $11,000**	Silver HSA 3500: **$5,000 / $10,000** Silver HSA 5100 & 5500: **$7,500 / $15,000**
Out-of-Pocket Maximum Individual / Family	**$7,500 / $15,000**	**$5,100 / $10,200**	**$5,500 / $11,000**	Silver HSA 3500: **$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
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: Covered in full after deductible, visits 4+: 20% Urgent/Specialist: 20% after deductible	0% after deductible	0% after deductible	50% after deductible
Telehealth		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 Combined 30 visits per year	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: 20 / 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 Oregon Voyager Small Group Medical Plans

	Bronze 7500	Bronze 9400	Bronze HSA 7500	
	IN NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	**$7,500 / $15,000**	**$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**	**$15,000 / $30,000**
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+: $35 no deductible Urgent: $35 no deductible Specialist: $100 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: 0% after deductible Urgent: 0% after deductible Specialist: 0% after deductible	0% after deductible	50% after deductible
Telehealth			0% after deductible	50% after deductible
Inpatient Hospital	30% after deductible	0% after deductible	0% after deductible	50% after deductible
Lab / X-ray	30% after deductible	0% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	0% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	0% after deductible	0% after deductible	50% after deductible
Emergency Services	30% after deductible	0% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$35 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	30% after deductible	0% after deductible	0% after deductible	90% after deductible

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2024 Oregon Voyager Small Group 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**	Standard Gold: **$5,000 / $10,000** Standard Silver: **$7,500 / $15,000** Standard Bronze: **$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$7,550 / $15,100**	**$9,450 / $18,900**	**$9,450 /$18,900**	Standard Gold: **$7,500 / $15,000** Standard Silver: **$11,250 / $22,500** Standard Bronze: **$15,000 / $30,000**
Preventive Services	Covered in full			50% after deductible
Preventive Drug Coverage	Covered in full			90% 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: $60 no deductible Specialist: $40 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $40 no deductible Urgent: $70 no deductible Specialist: $80 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible, visits 4+: $50 no deductible Urgent: $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 per 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

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