PacificSource HEALTH PLANS

2025 Oregon 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 exam and hardware benefit included on this plan.

Navigator network plans are available to businesses statewide.
Voyager network 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

2025 Oregon Small Group Medical Plans

	Gold 1000^	Gold 2000^	Gold 2500^	Gold 3500^	Gold HSA 3400	
	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**	**$3,400 / $6,800**	**$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**	**$3,400 / $6,800**	**$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

2025 Oregon 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	**$9,200 / $18,400**	**$9,200 / $18,400**	**$9,200 / $18,400**	**$9,200 / $18,400**	**$9,200 / $18,400**	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

2025 Oregon 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% after deductible 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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2025 Oregon Small Group Medical Plans

	Bronze 7500	Bronze HSA 8050	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$7,500 / $15,000**	**$8,050 / $16,100**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$8,050 / $16,100**	**$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	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% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	0% after deductible	50% after deductible
Emergency Services	30% 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	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	90% after deductible

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PacificSource HEALTH PLANS

2025 Oregon Small Group Medical Plans

	Standard Gold	Standard Silver	Standard Bronze	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,500 / $3,000**	**$5,500 / $11,000**	**$9,200 / $18,400**	Standard Gold: **$5,000 / $10,000** Standard Silver: **$7,500 / $15,000** Standard Bronze: **$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$7,000 / $14,000**	**$9,200 / $18,400**	**$9,200 / $18,400**	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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