PacificSource HEALTH PLANS

2025 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		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 exam and hardware benefit 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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PacificSource HEALTH PLANS

2025 Oregon Navigator Individual and Family Medical Plans

	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	**$9,000 / $18,000**	**$8,500 / $17,000**	**$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	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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PacificSource HEALTH PLANS

2025 Oregon Navigator Individual and Family Medical Plans

	Bronze 7000 Exchange	Bronze HSA 8050	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$7,000 / $14,000**	**$8,050 / $16,100**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$9,200 / $18,400**	**$8,050 / $16,100**	**$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: $75 no deductible Specialist: $125 no deductible	0% after deductible	50% after deductible
Telehealth	$75 no deductible	0% after deductible	50% after deductible
Inpatient Hospital	40% after deductible	0% after deductible	50% after deductible
Lab / X-ray	40% after deductible	0% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	0% after deductible	50% after deductible
Emergency Services	40% after deductible	0% after deductible	Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$75 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	40% 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	Same as in-network

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PacificSource HEALTH PLANS

2025 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	**$1,500 / $3,000**	**$5,500 / $11,000**	**$9,200 / $18,400**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$7,000 / $14,000**	**$9,200 / $18,400**	**$9,200 / $18,400**	**$25,000 / $50,000**
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 **Telehealth**	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
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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