



# Ensuring **your health**



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2021 Navigator Health Plans for **Oregon** Individuals and Families

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Serving the Portland area and Central Oregon



# At your service

The PacificSource difference is our exceptional customer service.

Combining technology that serves members with a human approach, we're focused on making health insurance easier for you and your family. So you can stay healthy and happy, while controlling healthcare costs.



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We've been putting members first with outstanding service since **1933**.

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# Health insurance is complicated. **We simplify it for you.**

**Service and tools to save you time and effort.**



## Four-state in-network area

See in-network providers in Idaho, Montana, Oregon, and Washington, as well as nationally through First Health<sup>®</sup> and in Alaska through First Choice Health<sup>™</sup>.



## Access anytime, from anywhere

Use our mobile app to access your health insurance information, including a convenient mobile ID card.



## No referrals

Need to see a specialist? None of our plans require you to see your primary care physician to get a referral first. (Some specialists may have their own referral requirements.)

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**30** seconds  
or less

That's the average wait time before someone answers when calling PacificSource customer service, according to internal call reports. No phone trees. Just real, knowledgeable people, ready to help.

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# Cost savings and convenience



## **On-demand access** to doctors by phone and video

Get the medical care you need, when and where you need it. Check your plan benefits for cost-sharing information.



## Find doctors **fast**

Our online search directory helps you find just the right doctor, any time you're ready.



## **\$0 copays** on preventive care and select preventive prescription drugs

There is no charge for well-baby or well-child care, preventive physicals, preventive mammograms, immunizations, preventive colonoscopies, and more, when receiving care from in-network providers. Plus, select preventive prescriptions are also available at no charge.

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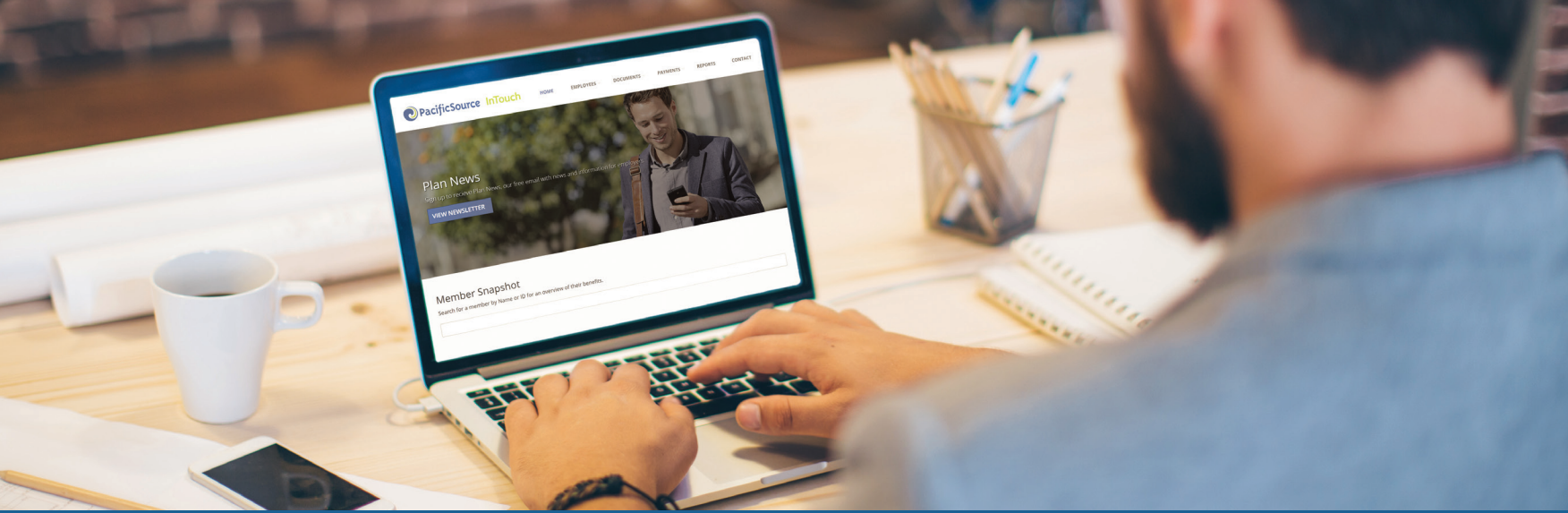
We cover more than **44,000** individual members  
and their families across the Greater Northwest.

PacificSource covers people just like you who get their health insurance  
direct, and not from an employer.

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Source: monthly enrollment report, March 2020





# Manage your health insurance benefits through our online portal from any **computer or mobile device.**



**Secure, convenient, member-only access to your insurance information and health resources via our InTouch portal and our myPacificSource app.**

## **Coverage information**

View coverage for common services, and even some uncommon ones.

## **EOBs**

See the explanation of benefits statements for your claims.

## **Check your status**

See how much of your deductible has been met.

## **ID cards**

Request ID cards and print temporary ones.

## **CaféWell**

Get access to a health engagement portal (for members 18 and older).

## **Estimate costs**

Find out how much procedures may cost with our treatment cost navigator.

# Navigator

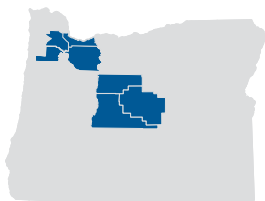
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**Navigator is our coordinated care product, where we work with members and their doctors to navigate care within a network of providers focused on the member's journey toward optimal health.**

Navigator products are designed to support member engagement and promote 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, nationally through contracts with First Health,<sup>®</sup> and in Alaska through contracts with First Choice Health.<sup>™</sup> Navigator products also offer out-of-network benefits, for more freedom and choice.

Our provider partners give members personalized care through high-quality health management, and help members better understand the costs associated with their health.



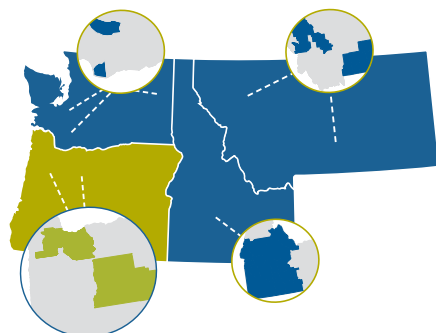
**Navigator is available in the following counties:**

Clackamas, Crook, Deschutes, Jefferson, Multnomah, Washington, and Yamhill.

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## Navigator products feature in-network coordinated care provider partners in each of our four states.



### Oregon: Bend Area Portland Metro

### Montana: Billings Bozeman Butte Helena Kalispell Missoula

### Idaho: Boise Nampa/Caldwell Pocatello Twin Falls

### Washington: Olympia Spokane Tacoma Vancouver

## The doctors **and hospitals** you want.

We've partnered with well-respected health centers and hospitals in each state so you will get top-notch quality of care and service.

### Oregon:



### Montana:



### Idaho:



### Washington:



In-network availability is based on member's plan and network.



# 2021 Oregon Navigator | Individual and Family Medical Plans

|                                                                                             | NON-HSA QUALIFIED PLANS                                                    |                                |                                                                            |                                |                                                                            |                                |                                                                            |                                |                                                                                                                                                                  |                                | HSA QUALIFIED PLANS                                                |                                | OREGON STANDARD PLANS                                                                                                                                 |                                |                                                                            |                                |                                                                    |                                |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------|--------------------------------|
| Product                                                                                     | Gold 1500 <sup>†</sup>                                                     |                                | Silver 3000                                                                |                                | Silver 4000                                                                |                                | Bronze 7000                                                                |                                | Catastrophic <sup>^</sup>                                                                                                                                        |                                | Bronze HSA 6900                                                    |                                | Standard Gold                                                                                                                                         |                                | Standard Silver                                                            |                                | Standard Bronze                                                    |                                |
|                                                                                             | Navigator                                                                  |                                | Navigator                                                                  |                                | Navigator                                                                  |                                | 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                 | IN NETWORK                                                                                                                                            | OUT OF NETWORK                 | IN NETWORK                                                                 | OUT OF NETWORK                 | IN NETWORK                                                         | OUT OF NETWORK                 |
| Deductible<br>Individual / Family                                                           | \$1,500 / \$3,000                                                          | \$10,000 / \$20,000            | \$3,000 / \$6,000                                                          | \$10,000 / \$20,000            | \$4,000 / \$8,000                                                          | \$10,000 / \$20,000            | \$7,000 / \$14,000                                                         | \$10,000 / \$20,000            | \$8,550 / \$17,100                                                                                                                                               | \$10,000 / \$20,000            | \$6,900 / \$13,800                                                 | \$10,000 / \$20,000            | \$1,500 / \$3,000                                                                                                                                     | \$10,000 / \$20,000            | \$3,650 / \$7,300                                                          | \$10,000 / \$20,000            | \$8,550 / \$17,100                                                 | \$10,000 / \$20,000            |
| Out-of-Pocket Maximum<br>Individual / Family                                                | \$5,500 / \$11,000                                                         | \$25,000 / \$50,000            | \$8,150 / \$16,300                                                         | \$25,000 / \$50,000            | \$7,900 / \$15,800                                                         | \$25,000 / \$50,000            | \$8,550 / \$17,100                                                         | \$25,000 / \$50,000            | \$8,550 / \$17,100                                                                                                                                               | \$25,000 / \$50,000            | \$6,900 / \$13,800                                                 | \$25,000 / \$50,000            | \$7,300 / \$14,600                                                                                                                                    | \$25,000 / \$50,000            | \$8,550 / \$17,100                                                         | \$25,000 / \$50,000            | \$8,550 / \$17,100                                                 | \$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: | 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%                            | 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%                            | Only for drugs on the Standard Preventive No-Cost Drug List (Affordable Care Act). In Network: Covered in Full. Out-of-network: 90% after deductible. |                                |                                                                            |                                |                                                                    |                                |
| Accident Benefit                                                                            | Covered in full* up to \$500, within 90 days of accident.                  |                                | Covered in full* up to \$500, within 90 days of accident.                  |                                | Covered in full* up to \$500, within 90 days of accident.                  |                                | Covered in full* up to \$500, within 90 days of accident.                  |                                | Covered in full* up to \$500, within 90 days of accident.                                                                                                        |                                | Covered in full* up to \$500, within 90 days of accident.          |                                | Not Covered                                                                                                                                           |                                | Not Covered                                                                |                                | Not Covered                                                        |                                |
|                                                                                             | AFTER DEDUCTIBLE, MEMBER PAYS:                                             |                                | AFTER DEDUCTIBLE, MEMBER PAYS:                                             |                                | AFTER DEDUCTIBLE, MEMBER PAYS:                                             |                                | 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<br>(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%                            | \$20*                                                                                                                                                 | 50%                            | \$40*                                                                      | 50%                            | \$50*                                                              | 50%                            |
| Office Visits<br>Primary, Urgent Care, and Specialist                                       | Primary/Urgent Care: \$20*<br>Specialist: \$40*                            | 50%                            | Primary/Urgent Care: \$35*<br>Specialist: 40%                              | 50%                            | Primary/Urgent Care: \$20*<br>Specialist: \$40*                            | 50%                            | Primary/Urgent Care: \$35*<br>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%                            | Primary: \$20*<br>Urgent Care: \$60*<br>Specialist: \$40*                                                                                             | 50%                            | Primary: \$40*<br>Urgent Care: \$70*<br>Specialist: \$80*                  | 50%                            | Primary: \$50*<br>Urgent Care: \$100*<br>Specialist: \$100*        | 50%                            |
| Inpatient Hospital                                                                          | 20%                                                                        | 50%                            | 40%                                                                        | 50%                            | 30%                                                                        | 50%                            | 40%                                                                        | 50%                            | Covered in Full                                                                                                                                                  | 50%                            | Covered in Full                                                    | 50%                            | 20%                                                                                                                                                   | 50%                            | 30%                                                                        | 50%                            | Covered in Full                                                    | 50%                            |
| Lab / X-ray                                                                                 | 20%                                                                        | 50%                            | 40%                                                                        | 50%                            | 30%                                                                        | 50%                            | 40%                                                                        | 50%                            | Covered in Full                                                                                                                                                  | 50%                            | Covered in Full                                                    | 50%                            | 20%                                                                                                                                                   | 50%                            | 30%                                                                        | 50%                            | Covered in Full                                                    | 50%                            |
| Physical, Occupational, and Speech Therapy<br>Combined 30 visits per year                   | 20%                                                                        | 50%                            | 40%                                                                        | 50%                            | 30%                                                                        | 50%                            | 40%                                                                        | 50%                            | Covered in Full                                                                                                                                                  | 50%                            | Covered in Full                                                    | 50%                            | \$20 if provided in an office setting*                                                                                                                | 50%                            | \$40 if provided in an office setting*                                     | 50%                            | \$50 if provided in an office setting*                             | 50%                            |
| Outpatient Surgery                                                                          | 20%                                                                        | 50%                            | 40%                                                                        | 50%                            | 30%                                                                        | 50%                            | 40%                                                                        | 50%                            | Covered in Full                                                                                                                                                  | 50%                            | Covered in Full                                                    | 50%                            | 20%                                                                                                                                                   | 50%                            | 30%                                                                        | 50%                            | Covered in Full                                                    | 50%                            |
| Emergency Services                                                                          | 20%                                                                        | 20%                            | 40%                                                                        | 40%                            | 30%                                                                        | 30%                            | 40%                                                                        | 40%                            | Covered in Full                                                                                                                                                  | Covered in Full                | Covered in Full                                                    | Covered in Full                | 20%                                                                                                                                                   | 20%                            | 30%                                                                        | 30%                            | Covered in Full                                                    | Covered in Full                |
| Chiropractic / Acupuncture<br>\$1,000 combined per year                                     | \$20*                                                                      | 50%                            | \$35*                                                                      | 50%                            | \$20*                                                                      | 50%                            | \$35*                                                                      | 50%                            | Not Covered                                                                                                                                                      | Not Covered                    | Covered in Full                                                    | 50%                            | Not Covered                                                                                                                                           | Not Covered                    | Not Covered                                                                | Not Covered                    | Not Covered                                                        | Not Covered                    |
| Prescription (Rx) Drug Coverage<br>Out-of-network: 30-day max fill, no more than 3 per year | Tier 1: \$15*<br>Tier 2: \$60*<br>Tier 3 & 4: 20%*                         | 90%                            | Tier 1: \$15*<br>Tier 2: \$60*<br>Tier 3 & 4: 40%*                         | 90%                            | 30%                                                                        | 90%                            | 40%                                                                        | 90%                            | Covered in Full                                                                                                                                                  | 90%                            | Covered in Full                                                    | 90%                            | Tier 1: \$10*<br>Tier 2: \$30*<br>Tier 3: 50%*<br>Tier 4: 50%* \$500 max/script                                                                       | 90%                            | Tier 1: \$15*<br>Tier 2: \$60*<br>Tier 3 & 4: 50%*                         | 90%                            | Tier 1: \$20*<br>Tier 2 - 4: Covered in Full                       | 90%                            |
| Pediatric Eye Exam<br>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*    | 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*    |
| Pediatric Vision Hardware<br>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 40% |                                | 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 |                                | 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 |                                |

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. ^Available only for people under 30, or people of any age with a hardship exemption or affordability exemption. †Adult vision included on this plan. 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. Accessibility help: For assistance reading this chart or the rest of the document, please call us at (888) 977-9299. TTY: 711 or (800) 735-3260.



## Kids in **focus**



### **Pediatric vision benefits for members through age 18**

Most of our medical plans include vision coverage, including routine eye exams for members through age 18 at no cost, when seeing an in-network doctor. Most plans also include vision hardware coverage up to \$150 for members through age 18, and amounts over that are covered based on your plan's specific benefits.

# Decide on dental



**Good dental health can lead to better overall health. You can add one of our dental plans to your health plan, or select dental-only. Available for purchase year-round, not just during open enrollment.**

## 2021 Oregon

## Individual and Family Dental Plan Comparison

| USE THIS CHART<br>TO COMPARE OUR<br>DENTAL PLANS                              | Dental Advantage<br>0-20-50 1000            |                                | Dental Advantage<br>0-20-50 1500            |                                | Kids Dental Advantage<br>0-20-50<br>(coverage for members age 18 and under) |                                |
|-------------------------------------------------------------------------------|---------------------------------------------|--------------------------------|---------------------------------------------|--------------------------------|-----------------------------------------------------------------------------|--------------------------------|
|                                                                               | Advantage Network                           |                                | Advantage Network                           |                                | Advantage Network                                                           |                                |
|                                                                               | IN NETWORK                                  | OUT OF NETWORK                 | IN NETWORK                                  | OUT OF NETWORK                 | IN NETWORK                                                                  | OUT OF NETWORK                 |
| <b>Annual Deductible</b><br>Individual / Family                               | N/A                                         | \$50 / \$150                   | N/A                                         | \$50 / \$150                   | N/A                                                                         | \$50 / \$150                   |
| <b>Annual Maximum Benefit</b><br>Per person, age 19 and older                 | \$1,000                                     |                                | \$1,500                                     |                                | N/A                                                                         |                                |
| <b>Pediatric Out-of-Pocket Maximum</b><br>Individual/Family, age 18 and under | \$350 / \$700                               | N/A                            | \$350 / \$700                               | N/A                            | \$350 / \$700                                                               | N/A                            |
|                                                                               | NO DEDUCTIBLE, MEMBER PAYS:                 | NO DEDUCTIBLE, MEMBER PAYS:    | NO DEDUCTIBLE, MEMBER PAYS:                 | NO DEDUCTIBLE, MEMBER PAYS:    | NO DEDUCTIBLE, MEMBER PAYS:                                                 | NO DEDUCTIBLE, MEMBER PAYS:    |
| <b>Class I Services</b>                                                       | Covered in Full                             | 20%                            | Covered in Full                             | 20%                            | Covered in Full                                                             | 20%                            |
|                                                                               | NO DEDUCTIBLE, MEMBER PAYS:                 | AFTER DEDUCTIBLE, MEMBER PAYS: | NO DEDUCTIBLE, MEMBER PAYS:                 | AFTER DEDUCTIBLE, MEMBER PAYS: | NO DEDUCTIBLE, MEMBER PAYS:                                                 | AFTER DEDUCTIBLE, MEMBER PAYS: |
| <b>Class II Services</b>                                                      | 20%                                         | 20%                            | 20%                                         | 20%                            | 20%                                                                         | 20%                            |
| <b>Class III Services</b>                                                     | 50%                                         | 50%                            | 50%                                         | 50%                            | 50%                                                                         | 50%                            |
| <b>Exclusion Period</b><br>Per person, age 19 and older                       | Class II: 6 months;<br>Class III: 12 months |                                | Class II: 6 months;<br>Class III: 12 months |                                | None                                                                        |                                |

This is a brief summary. Contact a Coverage Advisor at (855) 330-2792 or by email at [coverageadvisors@pacificsource.com](mailto:coverageadvisors@pacificsource.com). For more details, search individual and family plans at [PacificSource.com](https://www.pacificsource.com). Accessibility help: For assistance reading this chart or the rest of the document, please call us at (888) 977-9299. TTY: 711 or (800) 735-3260.





# Helping you choose a **health plan**



**Health plans can be complicated. We can help simplify your choice.**

All our health plans include coverage for preventive care, \$0 annual physicals from in-network providers, and most vaccinations.

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## **Non-HSA**

Non-HSA plans allow you to access some benefits for a copay prior to meeting your deductible (such as primary care, urgent care, or pharmacy).

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## **HSA**

HSA-qualified plans help you save money for healthcare expenses, such as deductibles and coinsurance. This type of plan requires that all major benefits be subject to the deductible.

HSA plans enable the use of HSA bank accounts. Contributions to HSA accounts are 100% tax deductible (up to the legal maximum) like an IRA. And withdrawals from your HSA to pay for qualified medical expenses are **tax-free**. Pro tip: Look for plan names with “HSA” in them.

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# At a glance your PacificSource coverage includes:

## Convenience

- ✓ **Easy online access** from desktop, tablet, or mobile app
- ✓ **Access to nearby care** doctors, hospitals and urgent care centers
- ✓ **Phone and video doctor visits** including behavioral health, through local providers, and nationally through Teladoc®
- ✓ **Digital member ID cards** via our website and mobile app
- ✓ **No referrals required by our plans** for you to see a specialist
- ✓ **Mail-order and retail pharmacy** for up to a 90-day supply
- ✓ **Online provider directory** to easily find who's in-network
- ✓ **Worry-free travel** with global emergency services from Assist America®

## Cost savings

- ✓ **\$0 copays** on select preventive care and preventive prescription drugs from in-network providers and pharmacies
- ✓ **Affordable fitness center access** from our partner, Active&Fit Direct™
- ✓ **Weight Watchers®** weight-management program discounts
- ✓ **24-Hour NurseLine at no cost**
- ✓ **Health education class reimbursement** up to \$150 for health and wellness classes, such as first aid/CPR, pregnancy, parenting, heart health, and nutrition
- ✓ **No-cost care management programs** for chronic conditions
- ✓ **Prenatal program** with information and consultations for expectant mothers
- ✓ **Help quitting smoking** or other tobacco use with the Quit For Life® tobacco cessation program

Additional benefits not considered as insurance.

# What's next?

**Here's how to enroll in our products:**



Choose a Navigator plan that best fits your needs.



Decide on dental



Contact your agent or our team for a quote



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## **We're here to help.**

We know that each step may require guidance,  
so please contact us with any questions.

**Phone:** (855) 330-2792

**Email:** [coverageadvisors@pacificsource.com](mailto:coverageadvisors@pacificsource.com)

[PacificSource.com](https://PacificSource.com)

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