PacificSource HEALTH PLANS

2025 Oregon Voyager Large Group Medical Plans

	500+20_20		750+20_20		1000+25_20		1500+25_20 1500+25_30	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$500 / $1,000**	**$1,000 / $2,000**	**$750 / $1,500**	**$1,500 / $3,000**	**$1,000 / $2,000**	**$2,000 / $4,000**	**$1,500 / $3,000**	**$3,000 / $6,000**
Out-of-Pocket Maximum Individual / Family	**$3,000 / $6,000**	**$6,000 / $12,000**	**$3,500 / $7,000**	**$6,000 / $12,000**	**$4,000 / $8,000**	**$8,000 / $16,000**	**$4,000 / $8,000**	**$8,000 / $16,000**
	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:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First 3 combined visits $5, then $20*	50%	First 3 combined visits $5, then $20*	50%	First 3 combined visits $5, then $25*	50%	First 3 combined visits $5, then $25*	50%
Urgent Care and Specialist	$20*	50%	$20*	50%	$25*	50%	$25*	50%
Inpatient Hospital	20%	50%	20%	50%	20%	50%	20% or 30%	50%
Lab / X-ray	No deductible up to $500, then 20%	50%	No deductible up to $500, then 20%	50%	No deductible up to $500, then 20%	50%	No deductible up to $500, then 20% or 30%	50%
Physical, Occupational, and Speech Therapy	$20*	50%	$20*	50%	$25*	50%	$25*	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$20*	50%	$20*	50%	$25*	50%	$25*	50%
Outpatient Surgery	20%	50%	20%	50%	20%	50%	20% or 30%	50%
Emergency Services	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*
Prescription (Rx) Drug Coverage	For more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com.							

*Not subject to deductible.

Plans are available to businesses statewide.

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 us at **888-530-8227,** OregonSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
Accessibility help: for assistance reading this table or the rest of the document, please call us at 888-977-9299, TTY: 711. We accept all relay calls.

PacificSource HEALTH PLANS

2025 Oregon Voyager Large Group Medical Plans

	2000+25_20 2000+25_30		2500+30_20 2500+30_30		2500+35_50		3000+30_20 3000+30_30	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$2,000 / $4,000**	**$4,000 / $8,000**	**$2,500 / $5,000**	**$5,000 / $10,000**	**$2,500 / $5,000**	**$5,000 / $10,000**	**$3,000 / $6,000**	**$6,000 / $12,000**
Out-of-Pocket Maximum Individual / Family	**$5,000 / $10,000**	**$10,000 / $20,000**	**$6,000 / $12,000**	**$12,000 / $24,000**	**$8,000 / $16,000**	**$12,000 / $24,000**	**$6,500 / $13,000**	**$13,000 / $26,000**
	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:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First 3 combined visits $5, then $25*	50%	First 3 combined visits $5, then $30*	50%	First 3 combined visits $5, then $35*	50%	First 3 combined visits $5, then $30*	50%
Urgent Care and Specialist	$25*	50%	$30*	50%	$70*	50%	$30*	50%
Inpatient Hospital	20% or 30%	50%	20% or 30%	50%	50%	50%	20% or 30%	50%
Lab / X-ray	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 50%	50%	No deductible up to $500, then 20% or 30%	50%
Physical, Occupational, and Speech Therapy	$25*	50%	$30*	50%	$35*	50%	$30*	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$25*	50%	$30*	50%	$35*	50%	$30*	50%
Outpatient Surgery	20% or 30%	50%	20% or 30%	50%	50%	50%	20% or 30%	50%
Emergency Services	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*	50%	50%	$250 plus 20%* or 30%*	$250 plus 20%* or 30%*
Prescription (Rx) Drug Coverage	For more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com.							

*Not subject to deductible.

Plans are available to businesses statewide.

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 us at **888-530-8227,** OregonSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
Accessibility help: for assistance reading this table or the rest of the document, please call us at 888-977-9299, TTY: 711. We accept all relay calls.

PacificSource HEALTH PLANS

2025 Oregon Voyager Large Group Medical Plans

	3500+35_30		4000+35_20 4000+35_30		4500+35_30		5000+35_30 5000+35_50	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$3,500 / $7,000**	**$7,000 / $14,000**	**$4,000 / $8,000**	**$8,000 / $16,000**	**$4,500 / $9,000**	**$9,000 / $18,000**	**$5,000 / $10,000**	**$10,000 / $20,000**
Out-of-Pocket Maximum Individual / Family	**$7,500 / $15,000**	**$15,000 / $30,000**	**$7,000 / $14,000**	**$14,000 / $28,000**	**$7,500 / $15,000**	**$15,000 / $30,000**	**$7,500 / $15,000 $8,500 / $17,000**	**$15,000 / $30,000**
	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:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First 3 combined visits $5, then $35*	50%	First 3 combined visits $5, then $35*	50%	First 3 combined visits $5, then $35*	50%	First 3 combined visits $5, then $35*	50%
Urgent Care and Specialist	$35*	50%	$35*	50%	$35*	50%	$35* or $70*	50%
Inpatient Hospital	30%	50%	20% or 30%	50%	30%	50%	30% or 50%	50%
Lab / X-ray	No deductible up to $500, then 30%	50%	No deductible up to $500, then 20% or 30%	50%	No deductible up to $500, then 30%	50%	No deductible up to $500, then 30% or 50%	50%
Physical, Occupational, and Speech Therapy	$35*	50%	$35*	50%	$35*	50%	$35*	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$35*	50%	$35*	50%	$35*	50%	$35*	50%
Outpatient Surgery	30%	50%	20% or 30%	50%	30%	50%	30% or 50%	50%
Emergency Services	30%	30%	20% or 30%	20% or 30%	30%	30%	30% or 50%	30% or 50%
Prescription (Rx) Drug Coverage	For more details on prescription drug coverage, search Pharmacy Plans at PacificSource.com.							

*Not subject to deductible.

Plans are available to businesses statewide.

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 us at **888-530-8227,** OregonSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
Accessibility help: for assistance reading this table or the rest of the document, please call us at 888-977-9299, TTY: 711. We accept all relay calls.

PacificSource HEALTH PLANS

2025 Oregon Voyager Large Group Medical Plans

	HSA 1650_20+Rx Non-embedded		HSA 3300_50+Rx		HSA 3300+Rx		HSA 4000+Rx		HSA 5000+Rx	
	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	$1,650 / $3,300	$7,500 / $15,000	$3,300 / $6,600	$7,500 / $15,000	$3,300 / $6,600	$7,500 / $15,000	$4,000 / $8,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$4,500 / $6,850	$15,000 / $30,000	$6,350 / $12,700	$15,000 / $30,000	$3,300 / $6,600	$15,000 / $30,000	$4,000 / $8,000	$20,000 / $40,000	$5,000 / $10,000	$20,000 / $40,000
	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:
Preventive Services	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Office Visits: Primary & Telehealth (including behavioral health)	First three visits $0, then 20%	50%	First three visits $0, then 50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Urgent Care and Specialist	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Inpatient Hospital	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Lab / X-ray	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Physical, Occupational, and Speech Therapy	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Outpatient Surgery	20%	50%	50%	50%	Covered in full	50%	Covered in full	50%	Covered in full	50%
Emergency Services	20%	20%	50%	50%	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prescription (Rx) Drug Coverage	20%	90%	50%	90%	Covered in full	90%	Covered in full	90%	Covered in full	90%

*Not subject to deductible.

Plans are available to businesses statewide.

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 us at **888-530-8227,** OregonSales@PacificSource.com, or go to PacificSource.com for details or to see a plan's Summary of Benefits.
Accessibility help: for assistance reading this table or the rest of the document, please call us at 888-977-9299, TTY: 711. We accept all relay calls.