PacificSource HEALTH PLANS

2026 Oregon Core Individual and Family Medical Plans

	Gold 1500^	Gold 3000^	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,500 / $3,000**	**$3,000 / $6,000**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$9,300 / $18,600**	**$8,000 / $16,000**	**Not covered**
Preventive Services	Covered in full		Not covered
Preventive Drug Coverage	Covered in full		Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident		Not covered
Office Visits: Primary and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $25 no deductible Specialist: $50 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $40 no deductible Specialist: $60 no deductible	Not covered
Telehealth			
Urgent Care	$25 no deductible	$40 no deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	20% after deductible		Not covered
Lab / X-ray	20% after deductible		Not covered
Physical, Occupational, and Speech Therapy Combined 30 visits per year	20% after deductible	$40 no deductible	Not covered
Outpatient Surgery	20% after deductible		Not covered
Emergency Services	20% after deductible		Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$25 no deductible	$40 no deductible	Not covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier1: $25 no deductible Tier 2: $50 no deductible Tier 3 & 4: 20% no deductible	Tier 1: $15 no deductible Tier 2: $40 no deductible Tier 3 & 4: 50% no deductible	Not covered
Pediatric Eye Exam	Covered in full		Same as in-network
Pediatric Vision Hardware	Covered in full up to $150 then subject to in-network deductible and 20%		Same as in-network

*Available only on a direct basis

^Adult vision exam and hardware benefit included on this plan.

For Core plans, the in-network service area includes ID, MT, OR, and Cowlitz and Clark counties in WA only. Outside the in-network service area, urgent and emergency care are covered through Aetna Signature Administrators. Besides urgent and emergency care, Core plans do not offer out-of-network benefits.

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PacificSource HEALTH PLANS

2026 Oregon Core Individual and Family Medical Plans

	Silver 4400*	Silver 4500	Silver 6000*	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$4,400 / $8,800**	**$4,500 / $9,000**	**$6,000 / $12,000**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$9,750 / $19,500**	**$9,750 / $19,500**	**$10,000 / $20,000**	**Not covered**
Preventive Services	Covered in full			Not covered
Preventive Drug Coverage	Covered in full			Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident			Not covered
Office Visits: Primary and Specialist **Telehealth**	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $30 no deductible Specialist: $60 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $30 no deductible Specialist: $60 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $40 no deductible Specialist: $100 no deductible	Not covered
Urgent Care	$30 no deductible	$30 no deductible	$70 no deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	30% after deductible			Not covered
Lab / X-ray	30% after deductible			Not covered
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible	30% after deductible	$40 no deductible if provided in an office setting	Not covered
Outpatient Surgery	30% after deductible			Not covered
Emergency Services	30% after deductible			Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$30 no deductible	$30 no deductible	$40 no deductible	Not covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	30% after deductible	30% after deductible	Tier 1: $20 no deductible Tier 2: $50 no deductible Tier 3 & 4: 50% no deductible	Not covered
Pediatric Eye Exam	Covered in full			Same as in-network
Pediatric Vision Hardware	Covered in full up to $150 then subject to in-network deductible and 30%			Same as in-network

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^Adult vision exam and hardware benefit included on this plan.

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PacificSource HEALTH PLANS

2026 Oregon Core Individual and Family Medical Plans

	Silver 7400*	Silver 7500	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$7,400 / $14,800**	**$7,500 / $15,000**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$8,400 / $16,800**	**$8,400 / $16,800**	**Not covered**
Preventive Services	Covered in full		Not covered
Preventive Drug Coverage	Covered in full		Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident		Not covered
Office Visits: Primary and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $35 no deductible Specialist: $70 no deductible		Not covered
Telehealth			
Urgent Care	$35 no deductible		Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	30% after deductible		Not covered
Lab / X-ray	30% after deductible		Not covered
Physical, Occupational, and Speech Therapy Combined 30 visits per year	30% after deductible		Not covered
Outpatient Surgery	30% after deductible		Not covered
Emergency Services	30% after deductible		Same as in-network
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	$35 no deductible		Not covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $20 no deductible Tier 2, 3, & 4: 50% after deductible		Not covered
Pediatric Eye Exam	Covered in full		Same as in-network
Pediatric Vision Hardware	Covered in full up to $150 then subject to in-network deductible and 30%		Same as in-network

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^Adult vision exam and hardware benefit included on this plan.

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PacificSource HEALTH PLANS

2026 Oregon Core Individual and Family Medical Plans

	Bronze HSA 7500	Bronze HSA 8300	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$7,500 / $15,000**	**$8,300 / $16,600**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$10,600 / $21,200**	**$8,300 / $16,600**	**Not covered**
Preventive Services	Covered in full		Not covered
Preventive Drug Coverage	Covered in full		Not covered
Accident Benefit	Covered in full up to $500, within 90 days of accident		Not covered
Office Visits: Primary and Specialist	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $75 no deductible Specialist: $125 no deductible	0% after deductible	Not covered
Telehealth			
Urgent Care	$75 no deductible	0% after deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	40% after deductible	0% after deductible	Not covered
Lab / X-ray	40% after deductible	0% after deductible	Not covered
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40% after deductible	0% after deductible	Not covered
Outpatient Surgery	40% after deductible	0% after deductible	Not covered
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	Not covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	40% after deductible	0% after deductible	Not covered
Pediatric Eye Exam	Covered in full		Same as in-network
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 and 0%	Same as in-network

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PacificSource HEALTH PLANS

2026 Oregon Core Individual and Family Medical Plans

	Standard Gold	Standard Silver	Standard Bronze HSA	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual / Family	**$1,800 / $3,600**	**$6,100 / $12,200**	**$9,200 / $18,400**	**Not covered**
Out-of-Pocket Maximum Individual / Family	**$8,150 / $16,300**	**$9,200 / $18,400**	**$9,200 / $18,400**	**Not covered**
Preventive Services	Covered in full			Not covered
Preventive Drug Coverage	Covered in full			Not covered
Accident Benefit	Not covered			Not covered
Office Visits: Primary and Specialist **Telehealth**	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $20 no deductible Specialist: $40 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $40 no deductible Specialist: $100 no deductible	Primary/telehealth combined visits 1-3: $5 no deductible Visits 4+: $50 no deductible Specialist: $150 no deductible	Not covered
Urgent Care	$60 no deductible	$70 no deductible	$100 no deductible	Same as in-network through Aetna Signature Administrators outside of ID, MT, OR, and Cowlitz and Clark counties in WA
Inpatient Hospital	20% after deductible	30% after deductible	0% after deductible	Not covered
Lab / X-ray	20% after deductible	30% after deductible	0% after deductible	Not covered
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	Not covered
Outpatient Surgery	20% after deductible	30% after deductible	0% after deductible	Not covered
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	Not covered
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 & 4: 50% no deductible	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	Not covered
Pediatric Eye Exam One exam per benefit period	Covered in full			Same as in-network
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 and 0%	Same as in-network

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