

	Platinum 500^	
	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$500 / \$1,000</b>	<b>\$5,000 / \$10,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$4,500 / \$9,000</b>	<b>\$9,500 / \$19,000</b>
<b>Preventive Services</b>	Covered in full	50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full	90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident	
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	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
<b>Telehealth</b>		
<b>Inpatient Hospital</b>	20% after deductible	50% after deductible
<b>Lab / X-ray</b>	20% no deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	\$10 no deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	50% after deductible
<b>Emergency Services</b>	\$250 plus 20% after deductible	
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$10 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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 plan exam and hardware benefit included on this plan

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## 2026 Oregon Small Group Medical Plans

	Gold 1000^	Gold 1500^	Gold 2000^	Gold 2500^	Gold 3500^	Gold HSA 3500	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	\$1,000 / \$2,000	\$1,500 / \$3,000	\$2,000 / \$4,000	\$2,500 / \$5,000	\$3,500 / \$7,000	\$3,500 / \$7,000	\$5,000 / \$10,000
<b>Out-of-Pocket Maximum</b> Individual / Family	\$7,000 / \$14,000	\$8,000 / \$16,000	\$8,000 / \$16,000	\$8,000 / \$16,000	\$8,250 / \$16,500	\$3,500 / \$7,000	Gold 1000: <b>\$15,125 / \$30,250</b> Gold 1500, 2000, 2500: <b>\$17,200 / \$34,400</b> Gold 3500: <b>\$21,200 / \$42,400</b> Gold HSA 3500: <b>\$8,300 / \$16,600</b>
<b>Preventive Services</b>	Covered in full						50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full						90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident						
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/telehealth combined visits 1-3: \$5 no deductible					0% after deductible	50% after deductible
<b>Telehealth</b>	Visits 4+: \$30 no deductible Urgent: \$30 no deductible Specialist: \$60 no deductible	Visits 4+: \$25 no deductible Urgent: \$25 no deductible Specialist: \$50 no deductible	Visits 4+: \$25 no deductible Urgent: \$25 no deductible Specialist: \$75 no deductible	Visits 4+: \$25 no deductible Urgent: \$25 no deductible Specialist: \$75 no deductible	Visits 4+: \$25 no deductible Urgent: \$25 no deductible Specialist: \$75 no deductible	0% after deductible	50% after deductible
<b>Inpatient Hospital</b>	30% after deductible					0% after deductible	50% after deductible
<b>Lab / X-ray</b>	30% no deductible					0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	\$30 no deductible	\$25 no deductible	\$25 no deductible	\$25 no deductible	\$25 no deductible	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	30% after deductible					0% after deductible	50% after deductible
<b>Emergency Services</b>	\$250 plus 30% after deductible					0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$30 no deductible	\$25 no deductible	\$25 no deductible	\$25 no deductible	\$25 no deductible	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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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## 2026 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
<b>Deductible</b> Individual / Family	<b>\$3,500 / \$7,000</b>	<b>\$4,500 / \$9,000</b>	<b>\$5,000 / \$10,000</b>	<b>\$5,500 / \$11,000</b>	<b>\$6,500 / \$13,000</b>	Silver 3500, 6500: <b>\$10,000 / \$20,000</b> Silver 4500, 5000, 5500: <b>\$7,500 / \$15,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$10,600 / \$21,200</b>	<b>\$10,600 / \$21,200</b>	<b>\$10,600 / \$21,200</b>	<b>\$10,600 / \$21,200</b>	<b>\$10,600 / \$21,200</b>	<b>\$21,200 / \$42,400</b>
<b>Preventive Services</b>	Covered in full					50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full					90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident					
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/telehealth combined visits 1–3: \$5 no deductible					50% after deductible
<b>Telehealth</b>	Visits 4+: \$50 no deductible Urgent: \$50 no deductible Specialist: \$100 no deductible	Visits 4+: \$40 no deductible Urgent: \$40 no deductible Specialist: \$100 no deductible	Visits 4+: \$40 no deductible Urgent: \$40 no deductible Specialist: \$80 no deductible	Visits 4+: \$35 no deductible Urgent: \$35 no deductible Specialist: \$70 no deductible	Visits 4+: \$60 no deductible Urgent: \$60 no deductible Specialist: \$80 no deductible	
<b>Inpatient Hospital</b>	40% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	
<b>Lab / X-ray</b>	40% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	40% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
<b>Outpatient Surgery</b>	40% after deductible	40% after deductible	50% after deductible	40% after deductible	35% after deductible	50% after deductible
<b>Emergency Services</b>	40% 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
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$50 no deductible	\$40 no deductible	\$40 no deductible	\$35 no deductible	\$60 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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

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

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## 2026 Oregon Small Group Medical Plans

	Silver HSA 3500	Silver HSA 5500	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$3,500 / \$7,000</b>	<b>\$5,500 / \$11,000</b>	Silver HSA 3500: <b>\$5,000 / \$10,000</b> Silver HSA 5500: <b>\$7,500 / \$15,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$8,300 / \$16,600</b>	<b>\$5,500 / \$11,000</b>	Silver HSA 3500: <b>\$16,600 / \$33,200</b> Silver HSA 5500: <b>\$13,250 / \$26,500</b>
<b>Preventive Services</b>	Covered in full		50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full		90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident		
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/telehealth combined visits 1–3: covered in full after deductible Visits 4+: 25% after deductible Urgent/Specialist: 25% after deductible	0% after deductible	50% after deductible
<b>Telehealth</b>			
<b>Inpatient Hospital</b>	25% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	25% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	25% after deductible	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	25% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	25% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	25% after deductible	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> Out-of-network: 30-day max fill, no more than 3 per year	25% after deductible	0% after deductible	90% after deductible

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## 2026 Oregon Small Group Medical Plans

	Bronze 7500	Bronze HSA 8300	
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$7,500 / \$15,000</b>	<b>\$8,300 / \$16,600</b>	<b>\$10,000 / \$20,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$10,600 / \$21,200</b>	<b>\$8,300 / \$16,600</b>	Bronze 7500: <b>\$21,200 / \$42,400</b> Bronze HSA 8300: <b>\$18,350 / \$36,700</b>
<b>Preventive Services</b>	Covered in full		50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full		90% after deductible
<b>Accident Benefit</b>	Covered in full up to \$500, within 90 days of accident		
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	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
<b>Telehealth</b>			
<b>Inpatient Hospital</b>	30% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	30% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> Combined 30 visits per year	30% after deductible	0% after deductible	50% after deductible
<b>Outpatient Surgery</b>	30% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	30% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$35 no deductible	0% after deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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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## 2026 Oregon Small Group Medical Plans

	Standard Gold	Standard Silver	Standard Bronze	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> Individual / Family	<b>\$1,800 / \$3,600</b>	<b>\$6,100 / \$12,200</b>	<b>\$9,200 / \$18,400</b>	Standard Gold: <b>\$5,000 / \$10,000</b> Standard Silver: <b>\$7,500 / \$15,000</b> Standard Bronze: <b>\$10,000 / \$20,000</b>
<b>Out-of-Pocket Maximum</b> Individual / Family	<b>\$8,150 / \$16,300</b>	<b>\$9,200 / \$18,400</b>	<b>\$9,200 / \$18,400</b>	Standard Gold: <b>\$18,500 / \$37,000</b> Standard Silver: <b>\$21,200 / \$42,400</b> Standard Bronze: <b>\$18,400 / \$36,800</b>
<b>Preventive Services</b>	Covered in full			50% after deductible
<b>Preventive Drug Coverage</b>	Covered in full			90% after deductible
<b>Accident Benefit</b>	Not covered			
<b>Office Visits: Primary, Urgent Care, and Specialist</b>	Primary/telehealth combined visits 1–3: \$5 no deductible			50% after deductible
<b>Telehealth</b>	Visits 4+: \$20 no deductible Urgent: \$60 no deductible Specialist: \$40 no deductible	Visits 4+: \$40 no deductible Urgent: \$70 no deductible Specialist: \$100 no deductible	Visits 4+: \$50 no deductible Urgent: \$100 no deductible Specialist: \$150 no deductible	50% after deductible
<b>Inpatient Hospital</b>	20% after deductible	30% after deductible	0% after deductible	50% after deductible
<b>Lab / X-ray</b>	20% after deductible	30% after deductible	0% after deductible	50% after deductible
<b>Physical, Occupational, and Speech Therapy</b> 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
<b>Outpatient Surgery</b>	20% after deductible	30% after deductible	0% after deductible	50% after deductible
<b>Emergency Services</b>	20% after deductible	30% after deductible	0% after deductible	Same as in-network
<b>Chiropractic / Acupuncture</b> Visits per benefit period: Chiro: 20 / Acu: 12	\$20 no deductible	\$40 no deductible	\$50 no deductible	50% after deductible
<b>Prescription (Rx) Drug Coverage</b> 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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