Availability Maps **by County**

More for less from our Navigator products

With our coordinated care products, a member's personal provider is navigating care within a coordinated network of health professionals. They promote better member engagement and shared decision making with providers.

Navigator is available for purchase by people living in the following counties: Clackamas, Crook, Deschutes, Jefferson, Multnomah, Washington, and Yamhill

For more information contact a Coverage Advisor at **(855) 330-2792** or by email at **coverageadvisors@pacificsource.com.**

IFP158_0819

2020 Navigator Medical Plans for **Oregon** Individuals and Families

Serving the Portland area and Central Oregon

PacificSource HEALTH PLANS

2020 Oregon Navigator | Individual and Family Medical Plans

NON-HSA QUALIFIED PLANS

	Gold 1500		Silver 3000		Silver 4000		Bronze 7000		Catastrophic^	
	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	$1,500 / $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	$8,150 / $16,300	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$5,000 / $10,000	$25,000 / $50,000	$8,150 / $16,300	$25,000 / $50,000	$7,900 / $15,800	$25,000 / $50,000	$8,150 / $16,300	$25,000 / $50,000	$8,150 / $16,300	$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:
Preventive Services	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%
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.	
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telemedicine (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%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $20* Specialist: $40*	50%	Primary/Urgent Care: $35* Specialist: 40%	50%	Primary/Urgent Care: $20* Specialist: $40*	50%	Primary/Urgent Care: $35* 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%
Inpatient Hospital	20%	50%	40%	50%	30%	50%	40%	50%	Covered in Full	50%
Lab / X-ray	20%	50%	40%	50%	30%	50%	40%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	20%	50%	40%	50%	30%	50%	40%	50%	Covered in Full	50%
Outpatient Surgery	20%	50%	40%	50%	30%	50%	40%	50%	Covered in Full	50%
Emergency Services	20%	20%	40%	40%	30%	30%	40%	40%	Covered in Full	Covered in Full
Chiropractic / Acupuncture $1,000 combined per year	$20*	50%	$35*	50%	$20*	50%	$35*	50%	Not Covered	Not Covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $15* Tier 2: $60* Tier 3 & 4: 20%*	90%	Tier 1: $15* Tier 2: $60* Tier 3 & 4: 40%*	90%	30%	90%	40%	90%	Covered in Full	90%
Pediatric Eye Exam 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%
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 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%

HSA QUALIFIED PLANS / **OREGON STANDARD PLANS**

	Bronze HSA 6750		Standard Gold		Standard Silver		Standard Bronze	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$6,750 / $13,500	$10,000 / $20,000	$1,000 / $2,000	$10,000 / $20,000	$3,550 / $7,100	$10,000 / $20,000	$7,900 / $15,800	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$6,750 / $13,500	$25,000 / $50,000	$7,300 / $14,600	$25,000 / $50,000	$8,150 / $16,300	$25,000 / $50,000	$7,900 / $15,800	$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:
Preventive Services	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Preventive Drug Coverage	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.		Not Covered		Not Covered		Not Covered	
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telemedicine (including behavioral health for adults)	Covered in Full	50%	$20*	50%	$40*	50%	$45*	50%
Office Visits Primary, Urgent Care, and Specialist	Covered in Full	50%	Primary: $20* Urgent Care: $60* Specialist: $40*	50%	Primary: $40* Urgent Care: $70* Specialist: $80*	50%	Primary: $45* Urgent Care: Covered in Full Specialist: $90*	50%
Inpatient Hospital	Covered in Full	50%	20%	50%	30%	50%	Covered in Full	50%
Lab / X-ray	Covered in Full	50%	20%	50%	30%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	Covered in Full	50%	$20 if provided in an office setting*	50%	$40 if provided in an office setting*	50%	$45 if provided in an office setting*	50%
Outpatient Surgery	Covered in Full	50%	20%	50%	30%	50%	Covered in Full	50%
Emergency Services	Covered in Full	Covered in Full	20%	20%	30%	30%	Covered in Full	Covered in Full
Chiropractic / Acupuncture $1,000 combined per year	Covered in Full	50%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Covered in Full	90%	Tier 1: $10* Tier 2: $30* Tier 3: 50%* Tier 4: 50%* $500 max/script	90%	Tier 1: $15* Tier 2: $60* Tier 3 & 4: 50%*	90%	Tier 1: $15* Tier 2 - 4: Covered in Full	90%
Pediatric Eye Exam 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*
Pediatric Vision Hardware One item per benefit period	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. 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.