Focus on **Vision**

Our vision plans focus on wellness and prevention.

Vision for kids

All of our medical plans include full no-cost coverage for in-network pediatric eye exams. Out-of-network eye exams are covered up to a maximum of $40 with no deductible. After that, member pays 100%. **Pediatric vision hardware is covered in full up to $150.** After that, it's subject to in-network deductible and then a cost-sharing fee up to 50%, depending upon the plan.

Vision for adults

Many of our medical plans include coverage for adult eye exams and vision hardware. When visiting an in-network provider, **eye exams are covered in full.** Out-of-network eye exams are covered up to a maximum of $40 with no deductible. After that, member pays 100%. **Adult vision hardware is covered in full up to $150.**

For more details on our vision benefits, please contact your broker or our team at the contact information listed on the back of this document.

Availability Maps **by County**

More for less from our Navigator and SmartChoice products

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

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

SmartChoice is available for purchase by businesses headquartered in the following counties: Benton, Coos, Curry, Douglas, Jackson, Josephine, Lane, Linn, Marion, and Polk

Competitive pricing and a leading brand with our Pathfinder products

Pathfinder is available for purchase by businesses headquartered in the following counties: Clackamas, Multnomah, and Washington

Freedom to choose with our Voyager products

Voyager is a preferred provider network, suited for a company culture that prefers a more self-directed experience.

Voyager is available for purchase by businesses headquartered in all Oregon counties.

Contact your broker or our team for a quote. We're happy to help, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Portland: (503) 699-6561 | (866) 540-1191 | portlandsales@pacificsource.com
Bend: (541) 330-8896 | (888) 877-7996 | bendsales@pacificsource.com
Springfield: (541) 686-1242 | (800) 624-6052 | springfieldsales@pacificsource.com
Medford: (541) 858-0381 | (800) 899-5866 | medfordsales@pacificsource.com
Web: PacificSource.com

SMG72_0819

2020 Medical Plans for **Oregon** Small Groups | 1–50

PacificSource HEALTH PLANS

2020 Oregon | Small Group Medical Plans

NON-HSA QUALIFIED PLANS

Product	Platinum 500^		Gold 1000^		Gold 2000^		Gold 2500^		Gold 3500^	
	Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice	
	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	$500 / $1,000	$5,000 / $10,000	$1,000 / $2,000	$5,000 / $10,000	$2,000 / $4,000	$5,000 / $10,000	$2,500 / $5,000	$5,000 / $10,000	$3,500 / $7,000	$5,000 / $10,000
Out-of-Pocket Maximum Individual / Family	$3,000 / $6,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000
	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%	$10*	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $10* Specialist: $20*	50%	Primary/Urgent Care: $25* Specialist: $60*	50%	Primary/Urgent Care: $25* Specialist: $60*	50%	Primary/Urgent Care: $25* Specialist: $60*	50%	Primary/Urgent Care: $25* Specialist: $60*	50%
Inpatient Hospital	20%	50%	30%	50%	30%	50%	30%	50%	30%	50%
Lab / X-ray	20%*	50%	30%*	50%	30%*	50%	30%*	50%	30%*	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$10*	50%	$25*	50%	$25*	50%	$25*	50%	$25*	50%
Outpatient Surgery	20%	50%	30%	50%	30%	50%	30%	50%	30%	50%
Emergency Services Copay waived if admitted	$250 plus 20%	$250 plus 20%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%
Chiropractic / Acupuncture $1,000 combined per year	$10*	50%	$25*	50%	$25*	50%	$25*	50%	$25*	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $5* Tier 2: $15* Tier 3 & 4: 20%*	90%	Tier 1: $10* Tier 2: $45* Tier 3 & 4: 30%*	90%	Tier 1: $10* Tier 2: $45* Tier 3 & 4: 30%*	90%	Tier 1: $10* Tier 2: $45* Tier 3 & 4: 30%*	90%	Tier 1: $10* Tier 2: $45* Tier 3 & 4: 30%*	90%

Product	Silver 3000		Silver 4500^		Silver 5500^		Silver 6500^		Bronze 7500	
	Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice	
	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	$3,000 / $6,000	$10,000 / $20,000	$4,500 / $9,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000	$6,500 / $13,000	$10,000 / $20,000	$7,500 / $15,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$8,150 / $16,300	$15,000 / $30,000	$7,500 / $15,000	$11,250 / $22,500	$7,500 / $15,000	$11,250 / $22,500	$7,500 / $15,000	$15,000 / $30,000	$7,500 / $15,000	$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:	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%	$10*	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $35* Specialist: 40%	50%	Primary/Urgent Care: $30* Specialist: $60*	50%	Primary/Urgent Care: $30* Specialist: $60*	50%	Primary/Urgent Care: $30* Specialist: $60*	50%	Primary/Urgent Care: $35* Specialist: Covered in Full	50%
Inpatient Hospital	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	50%
Lab / X-ray	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	50%
Outpatient Surgery	40%	50%	30%	50%	30%	50%	30%	50%	Covered in Full	50%
Emergency Services Copay waived if admitted	40%	40%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	Covered in Full	Covered in Full
Chiropractic / Acupuncture $1,000 combined per year	40%	50%	$30*	50%	$30*	50%	$30*	50%	$35*	50%
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: 40%*	90%	Tier 1: $15* Tier 2: $70* Tier 3 & 4: 30%*	90%	Tier 1: $15* Tier 2: $70* Tier 3 & 4: 30%*	90%	Tier 1: $15* Tier 2: $70* Tier 3 & 4: 30%*	90%	Covered in Full	90%

HSA QUALIFIED PLANS

Product	Gold HSA 3000		Silver HSA 3000		Silver HSA 4500		Silver HSA 5500		Bronze HSA 5000		Bronze HSA 6750	
	Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice		Navigator, Pathfinder, Voyager, or SmartChoice	
	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 Individual / Family	$3,000 / $6,000	$5,000 / $10,000	$3,000 / $6,000	$5,000 / $10,000	$4,500 / $9,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000	$5,000 / $10,000	$7,500 / $15,000	$6,750 / $13,500	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$3,000 / $6,000	$7,500 / $15,000	$6,750 / $13,500	$10,000 / $20,000	$4,500 / $9,000	$11,250 / $22,500	$5,500 / $11,000	$11,250 / $22,500	$6,750 / $13,500	$11,250 / $22,500	$6,750 / $13,500	$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:	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%
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%
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.	
	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 (including behavioral health for adults)	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Office Visits Primary, Urgent Care, and Specialist	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Inpatient Hospital	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Lab / X-ray	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Outpatient Surgery	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Emergency Services Copay waived if admitted	Covered in Full	Covered in Full	20%	20%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	50%	50%	Covered in Full	Covered in Full
Chiropractic / Acupuncture $1,000 combined per year	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Covered in Full	90%	20%	90%	Covered in Full	90%	Covered in Full	90%	50%	90%	Covered in Full	90%

OREGON STANDARD PLANS

Product	Standard Gold		Standard Silver		Standard Bronze	
	Voyager		Voyager		Voyager	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$1,000 / $2,000	$5,000 / $10,000	$3,550 / $7,100	$7,500 / $15,000	$7,900 / $15,800	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$7,300 / $14,600	$7,500 / $15,000	$8,150 / $16,300	$11,250 / $22,500	$7,900 / $15,800	$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:
Preventive Services	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Preventive Drug Coverage	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	Not Covered		Not Covered		Not Covered	
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:	
Telemedicine (including behavioral health for adults)	$20*	50%	$40*	50%	$45*	50%
Office Visits Primary, Urgent Care, and Specialist	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	20%	50%	30%	50%	Covered in Full	50%
Lab / X-ray	20%	50%	30%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	$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	20%	50%	30%	50%	Covered in Full	50%
Emergency Services Copay waived if admitted	20%	20%	30%	30%	Covered in Full	Covered in Full
Chiropractic / Acupuncture $1,000 combined per year	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	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%

Out-of-network services are covered up to an allowed amount. After that amount is reached, members may be subject to balance billing. ^ Adult vision included on this plan. * Not subject to deductible.
This is a brief summary. Contact us at **oregonsales@pacificsource.com** or go to **PacificSource.com** for details or to see a plan's Summary of Benefits.