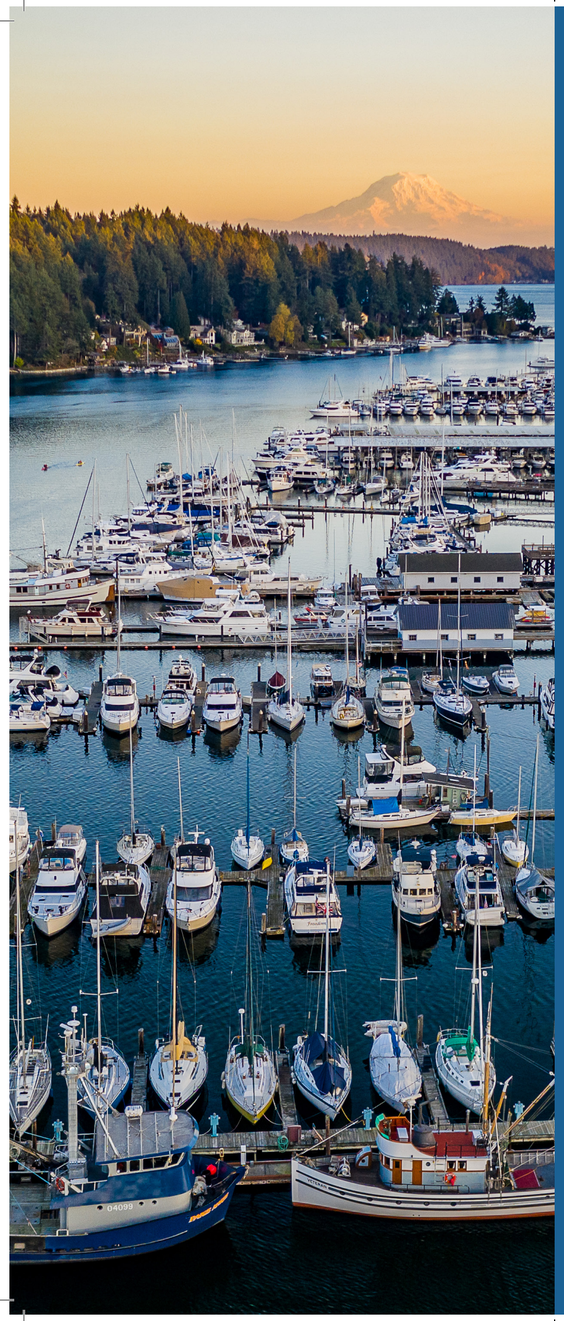

Availability Maps **by County**

More for less from our **Navigator** products

Navigator is our clinically integrated product, where a member's care is navigated within a coordinated network of health professionals. Navigator promotes better member engagement and shared decision making with providers.

Navigator gives access to a broad array of in-network providers, including local providers statewide, nationally, through contracts with First Health,® and in Alaska through contracts with First Choice Health.™ Navigator products also offer out-of-network benefits, for more freedom and choice.

Navigator is available for purchase by people living in the following counties: Clark, Pierce, Spokane, and Thurston.

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

IFP152_0720

2021 Medical Plans for **Washington** Individuals and Families

PacificSource HEALTH PLANS

2021 Washington | Individual and Family Medical Plans

	NON-HSA QUALIFIED PLANS										HSA QUALIFIED PLANS		WASHINGTON STANDARD PLANS					
Product	**Gold** 2000		**Silver** 3500†		**Silver** 5000		**Bronze** 7000		**Catastrophic^**		**Bronze** HSA 6900		**Cascade** Gold**		**Cascade** Silver**		**Cascade** Bronze**	
	Navigator		Navigator		Navigator		Navigator		Navigator		Navigator		Navigator		Navigator		Navigator	
	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	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$2,000 / $4,000	$10,000 / $20,000	$3,500 / $7,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000	$7,000 / $14,000	$10,000 / $20,000	$8,550 / $17,100	$10,000 / $20,000	$6,900 / $13,800	$10,000 / $20,000	$500 / $1,000	$10,000 / $20,000	$2,000 / $4,000	$10,000 / $20,000	$6,000 / $12,000	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$5,500 / $11,000	$25,000 / $50,000	$8,100 / $16,200	$25,000 / $50,000	$5,750 / $11,500	$25,000 / $50,000	$8,550 / $17,100	$25,000 / $50,000	$8,550 / $17,100	$25,000 / $50,000	$6,900 / $13,800	$25,000 / $50,000	$5,250 / $10,500	$25,000 / $50,000	$7,800 / $15,600	$25,000 / $50,000	$8,550 / $17,100	$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:	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%	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%	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.					
	AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		AFTER DEDUCTIBLE, MEMBER PAYS:		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)	$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%	Covered in Full	50%	$15*	50%	$25*	50%	$50*	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $20* Specialist: $40*	50%	Primary/Urgent Care: $40* Specialist: 30%	50%	Primary/Urgent Care: $15* Specialist: $30*	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%	Covered in Full	50%	Primary Care: $15* Urgent Care: $35* Specialist: $40*	50%	Primary Care: $25* Urgent Care: $60* Specialist: $60*	50%	Primary Care: $50* Urgent Care: $100* Specialist: $100	50%
Inpatient Hospital	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	$525*‡	50%	$800‡	50%	40%	50%
Lab / X-ray	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	Lab: $20* X-ray: $30*	50%	Lab: $35* X-ray: $60*	50%	40%	50%
Physical, Occupational, and Speech Therapy Visits per benefit period: PT & OT: 30 / ST: 30	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	$25*	50%	$35*	50%	40%	50%
Outpatient Surgery	20%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	$350	50%	$600	50%	40%	50%
Emergency Services	20%	20%	30%	30%	30%	30%	40%	40%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	$450	$450	$800	$800	40%	40%
Chiropractic / Acupuncture Visits per benefit period: Chiro: 12 / Acu: 12	$20*	50%	$40*	50%	$15*	50%	$35*	50%	Covered in Full	50%	Covered in Full	50%	$15*	50%	$25*	50%	$50*	50%
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: $15* Tier 2: $70* Tier 3 & 4: 20%*	90%	Tier 1: $15* Tier 2: $80* Tier 3 & 4: 30%*	90%	30%	90%	40%	90%	Covered in Full	90%	Covered in Full	90%	Tier 1: $10* Tier 2: $60* Tier 3 & 4: $100*	90%	Tier 1: $20* Tier 2: $70* Tier 3 & 4: $250	90%	Tier 1: $32* Tier 2, 3 & 4: 40%	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%	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 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 30%		Covered in full* up to $150 then subject to in-network deductible and 40%		Covered in Full	50%	Covered in full* up to $150 then subject to in-network deductible		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*

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 through Washington Healthplanfinder to people under 30, or people of any age with a hardship exemption or affordability exemption. **Available only through Washington Healthplanfinder. †Available only on a direct basis. ‡Per day copay, limit of 5 copays per stay. 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. Accessibility help: For assistance reading this chart or the rest of the document, please call us at (888) 977-9299. TTY: 711 or (800) 735-3260.