



2022 Medical Plans for **Washington Individuals and Families**



2022 Washington | Navigator Individual and Family Medical Plans

	NON-HSA QUALIFIED PLANS										HSA QUALIFIED PLANS		WASHINGTON STANDARD PLANS					
Product PD: Pediatric dental included	Gold 2000 ¹		Silver 3500 PD [†]		Silver 5000 ¹		Bronze 7000 ¹		Catastrophic [^]		Bronze HSA 7000 ¹		Cascade Gold ^{**}		Cascade Silver ^{**}		Cascade Bronze ^{**}	
	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	\$8,700 / \$17,400	\$10,000 / \$20,000	\$7,000 / \$14,000	\$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	\$8,700 / \$17,400	\$25,000 / \$50,000	\$7,000 / \$14,000	\$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:	
Telehealth (including behavioral health for adults)	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	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: \$50	50%	Primary/Urgent Care: \$15* Specialist: \$30*	50%	Primary/Urgent Care: \$35* Specialist: \$50	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 Combined 30 visits per benefit period	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*
Pediatric Dental Included	Yes		Yes		Yes		Yes		No		Yes		No		No		No	

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. [§]Includes Pediatric Dental when purchased direct from PacificSource. 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 table or the rest of the document, please call us at **888-977-9299; TTY 711 or 800-735-3260**.

Availability Map **by County**



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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.