NAVIGATOR

PacificSource HEALTH PLANS

2022 Medical Plans for Oregon Small Groups | 1–50

2022 Oregon | Navigator Small Group Medical Plans

NON-HSA QUALIFIED PLANS

Product	Platinum 500^		Gold 1000^		Gold 2000^		Gold 2500^		Gold 3500^	
	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	$6,000 / $12,000	$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:	
Telehealth (including behavioral health for adults)	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: $10* Specialist: $20*	50%	Primary/Urgent Care: $30* 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%	$30*	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 Visits per benefit period: Chiro: 20 / Acu: 12	$10*	50%	$30*	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: $15* 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 8150	
	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	$8,150 / $16,300	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$8,150 / $16,300	$15,000 / $30,000	$8,500 / $17,000	$11,250 / $22,500	$8,000 / $16,000	$11,250 / $22,500	$7,500 / $15,000	$15,000 / $30,000	$8,150 / $16,300	$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:	
Telehealth (including behavioral health for adults)	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	50%	Covered in Full*	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%	35%	50%	30%	50%	30%	50%	Covered in Full	50%
Lab / X-ray	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%
Outpatient Surgery	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%
Emergency Services Copay waived if admitted	40%	40%	$250 plus 35%	$250 plus 35%	$250 plus 30%	$250 plus 30%	$250 plus 30%	$250 plus 30%	Covered in Full	Covered in Full
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	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: 35%*	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

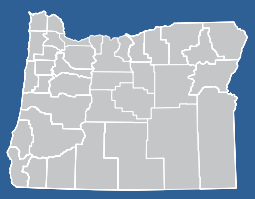
Product	Gold HSA 3000		Silver HSA 3000		Silver HSA 4500		Silver HSA 5500		Bronze HSA 7000	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$3,000 / $6,000	$5,000 / $10,000	$3,000 / $6,000	$5,000 / $10,000	$4,500 / $9,000	$7,500 / $15,000	$5,500 / $11,000	$7,500 / $15,000	$7,000 / $14,000	$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	$7,000 / $14,000	$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:	
Telehealth (including behavioral health for adults)	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	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%	Covered in Full	50%
Inpatient Hospital	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	Covered in Full	50%
Lab / X-ray	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	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%	Covered in Full	50%
Outpatient Surgery	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	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	Covered in Full	Covered in Full
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	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%	Covered in Full	90%

OREGON STANDARD PLANS

Product	Standard Gold		Standard Silver		Standard Bronze	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	$1,500 / $3,000	$5,000 / $10,000	$3,650 / $7,300	$7,500 / $15,000	$8,700 / $17,400	$10,000 / $20,000
Out-of-Pocket Maximum Individual / Family	$7,300 / $14,600	$7,500 / $15,000	$8,550 / $17,100	$11,250 / $22,500	$8,700 / $17,400	$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:	
Telehealth (including behavioral health for adults)	$20*	50%	$40*	50%	$50*	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: $50* Urgent Care: $100* Specialist: $100*	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%	$50 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 Visits per benefit period: Chiro: 20 / Acu: 12	$20*	50%	$40*	50%	$50*	50%
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: $20* 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.
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**



More for less from our Navigator products

Navigator is a coordinated care product, where each member's care is managed within a network of local, highly rated healthcare professionals. Navigator promotes better member engagement, self-management, cost control, and shared decision making with providers.

Navigator is available for purchase by businesses located 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.

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