



2022 Medical Plans for **Washington Small Groups** | 1–50



2022 Washington | Navigator Small Group Medical Plans

	NON-HSA QUALIFIED PLANS																				HSA QUALIFIED PLANS															
Product PD: Pediatric dental included	Platinum 500 PD^		Gold 1000 PD^		Gold 1500 PD^		Gold 2000 PD^		Gold 2500 PD^		Gold 3500 PD^		Silver 3000 PD		Silver 4500 PD^		Silver 5500 PD^		Silver 6500 PD^		Bronze 8150 PD		Gold HSA 3000 PD		Silver HSA 3000 PD		Silver HSA 4500 PD		Silver HSA 5500 PD		Bronze HSA 6000 PD		Bronze HSA 7000 PD			
	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	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	\$500 / \$1,000	\$5,000 / \$10,000	\$1,000 / \$2,000	\$5,000 / \$10,000	\$1,500 / \$3,000	\$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	\$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	\$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	\$6,000 / \$12,000	\$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	\$6,850 / \$13,700	\$7,500 / \$15,000	\$6,700 / \$13,400	\$7,500 / \$15,000	\$6,000 / \$12,000	\$7,500 / \$15,000	\$6,000 / \$12,000	\$7,500 / \$15,000	\$6,000 / \$12,000	\$7,500 / \$15,000	\$8,150 / \$16,300	\$15,000 / \$30,000	\$8,500 / \$17,000	\$11,250 / \$22,500	\$8,000 / \$16,000	\$11,250 / \$22,500	\$8,000 / \$16,000	\$15,000 / \$30,000	\$8,150 / \$16,300	\$15,000 / \$30,000	\$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	\$6,900 / \$13,800	\$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:	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:	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%	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%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%	Covered in Full	90%		
	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:		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%	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%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	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: \$50*	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: \$35* Specialist: \$50	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: \$95*	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%		
Inpatient Hospital	10%	50%	25%	50%	20%	50%	20%	50%	20%	50%	20%	50%	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%		
Lab / X-ray	10%*	50%	25%*	50%	20%*	50%	20%*	50%	20%*	50%	20%*	50%	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%	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 benefit period	\$10*	50%	\$30*	50%	\$30*	50%	\$25*	50%	\$25*	50%	\$25*	50%	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	Covered in Full	50%	Covered in Full	50%	50%	50%	Covered in Full	50%		
Outpatient Surgery	10%	50%	25%	50%	20%	50%	20%	50%	20%	50%	20%	50%	40%	50%	35%	50%	30%	50%	30%	50%	Covered in Full	50%	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	\$250 plus 10%	\$250 plus 10%	\$250 plus 25%	\$250 plus 25%	\$250 plus 20%	\$250 plus 20%	\$250 plus 20%	\$250 plus 20%	\$250 plus 20%	\$250 plus 20%	\$250 plus 20%	\$250 plus 20%	40%	40%	\$250 plus 35%	\$250 plus 35%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	\$250 plus 30%	Covered in Full	Covered in Full	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 Visits per benefit period: Chiro: 12 / Acu: 12	\$10*	50%	\$25*	50%	\$25*	50%	\$25*	50%	\$25*	50%	\$25*	50%	40%	50%	\$30*	50%	\$30*	50%	\$30*	50%	\$30*	50%	Covered in Full	50%	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	Tier 1: \$5* Tier 2: \$15* Tier 3 & 4: 20%*	90%	Tier 1: \$15* Tier 2: \$45* Tier 3 & 4: 30%*	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%	Tier 1: \$15* Tier 2: \$70* 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%	Tier 1: \$15* Tier 2: \$70* Tier 3 & 4: 30%*	90%	Covered in Full	90%	Covered in Full	90%	20%	90%	Covered in Full	90%	Covered in Full	90%	50%	90%	Covered in Full	90%

Pediatric dental coverage is included with all of these plans. 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 WashingtonSales@PacificSource.com or go to PacificSource.com for details or to see a plan's Summary of Benefits.

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Availability Map **by County**



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We're here Monday through Friday from 8:00 a.m. to 5:00 p.m.**

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