



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



2022 Oregon | Navigator Individual and Family Medical Plans

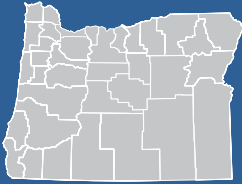
Product	NON-HSA QUALIFIED PLANS															HSA QUALIFIED PLANS		OREGON STANDARD PLANS						
	Gold 1500 [†]		Silver 2900 ^{††}		Silver 3000		Silver 3600 ^{††}		Silver 3900 ^{††}		Silver 4000		Bronze 7000		Catastrophic [^]		Bronze HSA 7000		Standard Gold		Standard Silver		Standard Bronze	
	IN NETWORK	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	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Deductible Individual / Family	\$1,500 / \$3,000	\$10,000 / \$20,000	\$2,900 / \$5,800	\$10,000 / \$20,000	\$3,000 / \$6,000	\$10,000 / \$20,000	\$3,600 / \$7,200	\$10,000 / \$20,000	\$3,900 / \$7,800	\$10,000 / \$20,000	\$4,000 / \$8,000	\$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	\$1,500 / \$3,000	\$10,000 / \$20,000	\$3,650 / \$7,300	\$10,000 / \$20,000	\$8,700 / \$17,400	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$6,500 / \$13,000	\$25,000 / \$50,000	\$8,150 / \$16,300	\$25,000 / \$50,000	\$8,150 / \$16,300	\$25,000 / \$50,000	\$8,550 / \$17,100	\$25,000 / \$50,000	\$7,900 / \$15,800	\$25,000 / \$50,000	\$7,900 / \$15,800	\$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	\$7,300 / \$14,600	\$25,000 / \$50,000	\$8,550 / \$17,100	\$25,000 / \$50,000	\$8,700 / \$17,400	\$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:	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%
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%	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	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.		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.		Not Covered		Not Covered		Not Covered	
	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%	Telemedicine and office combined visits 1-3 no deductible, covered in full. Visits 4+ covered in full after deductible.	50%	Covered in Full	50%	\$20*	50%	\$40*	50%	\$50*	50%
Office Visits Primary, Urgent Care, and Specialist	Primary/Urgent Care: \$20* Specialist: \$40*	50%	Primary/Urgent Care: \$35* Specialist: 40%	50%	Primary/Urgent Care: \$35* Specialist: 40%	50%	Primary Care: \$40* Urgent Care: \$70* Specialist: \$80*	50%	Primary/Urgent Care: \$20* Specialist: \$40*	50%	Primary/Urgent Care: \$20* Specialist: \$40*	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: \$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%	40%	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	30%	50%	Covered in Full	50%
Lab / X-ray	20%	50%	40%	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	30%	50%	Covered in Full	50%
Physical, Occupational, and Speech Therapy Combined 30 visits per year	20%	50%	40%	50%	40%	50%	\$40 if provided in an office setting*	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	\$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%	40%	50%	40%	50%	30%	50%	30%	50%	30%	50%	40%	50%	Covered in Full	50%	Covered in Full	50%	20%	50%	30%	50%	Covered in Full	50%
Emergency Services	20%	20%	40%	40%	40%	40%	30%	30%	30%	30%	30%	30%	40%	40%	Covered in Full	Covered in Full	Covered in Full	Covered in Full	20%	20%	30%	30%	Covered in Full	Covered in Full
Chiropractic / Acupuncture Visits per benefit period: Chiro: 20 / Acu: 12	\$20*	50%	\$35*	50%	\$35*	50%	\$40*	50%	\$20*	50%	\$20*	50%	\$35*	50%	Covered in Full	50%	Covered in Full	50%	\$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: \$20* Tier 2: \$60* Tier 3 & 4: 20%*	90%	Tier 1: \$15* Tier 2: \$60* Tier 3 & 4: 40%*	90%	Tier 1: \$15* Tier 2: \$60* Tier 3 & 4: 40%*	90%	Tier 1: \$15* Tier 2: \$60* Tier 3 & 4: 50%*	90%	30%	90%	30%	90%	40%	90%	Covered in Full	90%	Covered in Full	90%	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%
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*	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 40%		Covered in full* up to \$150 then subject to in-network deductible and 40%		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 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* 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		

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 for people under 30, or people of any age with a hardship exemption or affordability exemption. †Adult vision included on this plan. †† Available only on a direct basis.

This is a brief summary. Contact a Coverage Advisor at **855-330-2792** or by email at CoverageAdvisors@PacificSource.com. Go to [PacificSource.com](https://www.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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Navigator is a coordinated care product, where we work with local healthcare providers who support each member on their journey toward optimal health. Navigator promotes member engagement, self-management, and shared decision making with providers.

Navigator is available for purchase by people living in all Oregon counties.

For more information or to enroll, contact a Coverage Advisor at **855-330-2792**
or by email at CoverageAdvisors@PacificSource.com.