



NAVIGATOR



Planes Médicos 2023

Individuales y Familiares para Washington



2023 Washington | Planes Médicos Individuales y Familiares Navigator

	Gold 2000 PD		Silver 3500 PD†		Silver 5000 PD		Bronze 7000 PD		HSA-QUALIFIED PLAN		WASHINGTON STANDARD PLANS					
	Bronze HSA 7050 PD		Cascade Gold**		Cascade Silver**		Cascade Bronze**		Bronze HSA 7050 PD		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
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	\$7,050 / \$14,100	\$10,000 / \$20,000	\$600 / \$1,200	\$10,000 / \$20,000	\$2,500 / \$5,000	\$10,000 / \$20,000	\$6,000 / \$12,000	\$10,000 / \$20,000
Out-of-Pocket Maximum Individual / Family	\$6,000 / \$12,000	\$25,000 / \$50,000	\$8,600 / \$17,200	\$25,000 / \$50,000	\$7,250 / \$14,500	\$25,000 / \$50,000	\$8,550 / \$17,100	\$25,000 / \$50,000	\$7,050 / \$14,100	\$25,000 / \$50,000	\$5,900 / \$11,800	\$25,000 / \$50,000	\$8,500 / \$17,000	\$25,000 / \$50,000	\$8,550 / \$17,100	\$25,000 / \$50,000

Preventive Services	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible
Preventive Drug Coverage	Covered in full	90% after deductible	Covered in full	90% after deductible	Covered in full	90% after deductible	Covered in full	90% after deductible	Covered in full	90% after deductible	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					

Office Visits Primary (including behavioral health), Urgent Care, and Specialist	Primary/Urgent: \$20 no deductible Specialist: \$40 no deductible	50% after deductible	Primary/Urgent: \$40 no deductible Specialist: \$80 after deductible	50% after deductible	Primary/Urgent: \$15 no deductible Specialist: \$30 no deductible	50% after deductible	Primary/Urgent: \$35 no deductible Specialist: \$50 after deductible	50% after deductible	0% after deductible	50% after deductible	Primary: \$15 no deductible Urgent: \$35 no deductible Specialist: \$40 no deductible	50% after deductible	Primary: \$30 no deductible Urgent/Specialist: \$65 no deductible	50% after deductible	Primary: \$50 no deductible Urgent: \$100 no deductible Specialist: \$100 after deductible	50% after deductible
Telehealth	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	Covered in full	50% after deductible	0% after deductible	50% after deductible	\$15 no deductible	50% after deductible	\$30 no deductible	50% after deductible	\$50 no deductible	50% after deductible
Inpatient hospital	20% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	\$525 no deductible (per day copay, limit 5 copays per stay)	50% after deductible	\$800 after deductible (per day copay, limit 5 copays per stay)	50% after deductible	40% after deductible	50% after deductible
Lab / X-ray	20% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	Lab: \$20 no deductible X-ray: \$30 no deductible	50% after deductible	Lab: \$40 no deductible X-ray: \$65 no deductible	50% after deductible	40% after deductible	50% after deductible
Physical, Occupational, and Speech Therapy Combined 30 visits per benefit period	20% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	\$25 no deductible	50% after deductible	\$40 no deductible	50% after deductible	40% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	35% after deductible	50% after deductible	30% after deductible	50% after deductible	40% after deductible	50% after deductible	0% after deductible	50% after deductible	\$350 after deductible	50% after deductible	\$600 after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency Services	20% after deductible	20% after deductible	35% after deductible	35% after deductible	30% after deductible	30% after deductible	40% after deductible	40% after deductible	0% after deductible	0% after deductible	\$450 after deductible	\$450 after deductible	\$800 after deductible	\$800 after deductible	40% after deductible	40% after deductible
Chiropractic / Acupuncture Visits per benefit period Chiro: 12 / Acu: 12	\$20 no deductible	50% after deductible	\$40 no deductible	50% after deductible	\$15 no deductible	50% after deductible	\$35 no deductible	50% after deductible	0% after deductible	50% after deductible	\$15 no deductible	50% after deductible	\$30 no deductible	50% after deductible	\$50 no deductible	50% after deductible
Prescription (Rx) Drug Coverage Out-of-network: 30-day max fill, no more than 3 per year	Tier 1: \$15 no deductible Tier 2: \$70 no deductible Tier 3 & 4: 20% no deductible	90% after deductible	Tier 1: \$20 no deductible Tier 2: \$80 no deductible Tier 3 & 4: 35% no deductible	90% after deductible	30% after deductible	90% after deductible	40% after deductible	90% after deductible	0% after deductible	90% after deductible	Tier 1: \$10 no deductible Tier 2: \$60 no deductible Tier 3 & 4: \$100 no deductible	90% after deductible	Tier 1: \$25 no deductible Tier 2: \$75 no deductible Tier 3 & 4: \$250 after deductible	90% after deductible	Tier 1: \$32 no deductible Tier 2, 3, & 4: 40% after deductible	90% after deductible
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	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 35%		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 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		Yes		No		No		No	

**Disponible sólo a través de Washington Healthplanfinder.

†Sólo disponible de forma directa.

Los servicios fuera de la red se cubren hasta el monto permitido. Una vez alcanzado ese monto, los miembros pudieran tener que pagar el saldo facturado. Este es un breve resumen. Póngase en contacto con un Asesor de Cobertura al teléfono **855-330-2792** o al email CoverageAdvisors@PacificSource.com. Visite PacificSource.com para obtener información detallada o consultar el Resumen de Beneficios de un plan. Ayuda con la accesibilidad: si usted necesita ayuda para leer esta tabla o el resto del documento, por favor llámenos al **888-977-9299**, TTY: 711. Aceptamos llamadas del servicio de retransmisión.

Mapa de disponibilidad **por condado**



Nuestros productos **Navigator** le dan **más por menos**

Navigator es nuestro producto clínicamente integrado. Colaboramos con nuestros miembros y con una red local de proveedores del cuidado de la salud altamente calificados, quienes están enfocados en proporcionar resultados de calidad.

El plan Navigator:

- Lo apoya en su camino hacia una salud óptima
- Valora y promueve su participación en cuestiones del cuidado de la salud
- Le ofrece recursos y herramientas de autocontrol
- Enfatiza la toma de decisiones compartida con los proveedores

Navigator puede ser contratado por personas que vivan los siguientes condados: Clark, Pierce, Spokane y Thurston

Para obtener más información, comuníquese con un Asesor de Cobertura al teléfono **855-767-2312**, TTY: 711 (aceptamos llamadas del servicio de retransmisión) o al email CoverageAdvisors@PacificSource.com.